Primary Care
Brown Health Medical Group
BROWNHealth UNIVERSITY

Patient name (Print): _____

Preferred name: _____

Preferred pronoun: _____

Patient date of birth: _____ Date: _____

Permissions

Permission to Leave Message Containing Health Information		
I authorize Brown University Health to leave or send messages to my:		
Method	**Phone Number**	**Check all that apply**
Home phone (Voice message)		☐ None ☐ General/appointment reminders ☐ Detailed/clinical
Cell phone (Voice message)		☐ None ☐ General/appointment reminders ☐ Detailed/clinical
Cell phone* (Text message)		☐ None ☐ General/appointment reminders ☐ Detailed/clinical

**Note: By providing a telephone number and checking the appropriate box above, you are consenting to be contacted by SMS text message. Message & data rates may apply. You can reply STOP to opt-out of further messaging.*

Permission to Communicate Health Information		
All medical records are confidential. We require written authorization to discuss medical information with anyone other than the patient. By signing the authorization below, you are giving permission to discuss information contained in the medical record with another individual.		
I, _____ give the clinicians and staff of Brown University Health permission to discuss my diagnosis, procedures, and/or treatment plans with:		
Person 1	Name #1:	Relationship:
	Home phone:	Cell phone:
Person 2	Name #2:	Relationship:
	Home phone:	Cell phone:
Person 3	Name #3:	Relationship:
	Home phone:	Cell phone:
I agree and understand that my medical record contains my personal health information and may contain information that is considered sensitive under the law. Brown University Health supports integrated behavioral health, and I understand that mental health or substance use conditions may also be discussed with the above-listed individuals.		
Please note: If you have a Healthcare Power of Attorney (HCPOA), those listed above should match the Designated Health Care Agents on your HCPOA. If you have not yet provided us with a copy of your HCPOA, please fax or mail a copy of this to our practice to keep on file.		
Name:		Date of birth:
Signature:		Date:

You may update this information at any time.
For staff: Scan to patient-level / document type permission to communicate health information.