ProHealth™ PHYSICIANS
Part of OptumCare®

ProHealthMD.com

Permission to communicate (page 1 of 2)

We need your written authorization if you wish us to communicate with family members or others involved in your care (or your child's care), or to communicate with you by text message or voicemail. ***Note that once such person/s are provided with information, the information no longer is within the control of ProHealth and it is possible that they will disclose it to others.***

This permission also authorizes ProHealth to communicate with the authorized persons by phone (including voice messages)/text/email. It also authorizes us to send you messages by text or voicemail.

This permission is NOT an authorization to release medical records, or consent to treatment.

I, _____ authorize ProHealth Physicians /_____ to release or discuss:

☐ My health information (Date of birth ____/____/_____)

☐ My minor child/children's health information:

Child's name _____ Date of birth ____/____/_____

Child's name _____ Date of birth ____/____/_____

Child's name _____ Date of birth ____/____/_____

Child's name _____ Date of birth ____/____/_____

To or with:

Name: _____ Phone number: _____

Relationship: (Circle one) *Note: the person must be at least 18 years of age*

Spouse/Partner	Cousin	In-law
Mother/Father	Sibling	Friend
Grandparent	Foster Parent	Nanny, babysitter or au pair
Step-parent	Niece/Nephew	Son/Daughter
Aunt/Uncle	Social or DCF Worker	My health care representative

Other: _____

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Permission to communicate (page 2 of 2)

Additional Authorized Person, if desired:

Relationship: (Circle one) *Note: the person must be at least 18 years of age*

Spouse/Partner	Cousin	In-law
Mother/Father	Sibling	Friend
Grandparent	Foster Parent	Nanny, babysitter or au pair
Step-parent	Niece/Nephew	Son/Daughter
Aunt/Uncle	Social or DCF Worker	My health care representative

Other: _____

I will be provided with a copy of this form if I choose to sign it. I understand that I am under no obligation to sign this form and that ProHealth Physicians may not condition treatment, payment, or enrollment/eligibility for benefits on my decision to sign this form. I understand that I may revoke this Permission by notifying ProHealth Physicians in writing of my revocation. To obtain information on how to revoke my Permission or to receive a copy of my revocation, contact ProHealth Physicians' Privacy Official at 3 Farm Glen Boulevard, Farmington, CT 06032, Attention: Privacy Officer. I am aware that my revocation will not be effective until received by ProHealth and will not affect uses and/or disclosures prior to receipt of the revocation. This permission is effective until revoked.

This permission may not be altered in any manner. If altered, in the sole discretion of ProHealth it may be considered void and of no effect.

NOT EFFECTIVE UNLESS SIGNED AND DATED

_____ _____

Individual's signature Date