Communication and Records Consent Form

Thank you for choosing **Maui Urology, LLC**. Our goal is for you to receive the best care possible. As part of your continuum of care, Maui Urology uses technology to facilitate many aspects of our practice. Maui Urology will use various methods of communication that may include **email, text and phone**. Additionally, we participate in **CommonWell**. This service allows the network of participating healthcare providers to securely identify, send and receive your accurate and approved medical information. This free service is offered so that your health information may be quickly and securely available to your doctors, who may also participate in the **CommonWell/CareQuality** network, allowing your doctors to make the best decisions possible to optimize your health, based upon the most recent information.

Authorization for Release of Protected Health Information

Consent:

I authorize Maui Urology, LLC to disclose information related to my visit through text, voicemail, answering machine or email. Additionally, I authorize Maui Urology to disclose information related to my visit via the CommonWell network with this consent. I understand that this authorization is revocable by me at any time if I provide written, signed notice except to the extent that action has been taken on this release. I understand that my healthcare information at Maui Urology, LLC is protected and I have received a copy of their Notice of Privacy Practices.

Maui Urology "opts in" all patients for communication and record network participation unless otherwise specified.

____ ____

Patient Name (Print) **Patient DOB** **Date**

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Patient/Parent Signature

IF YOU DECLINE TO OPT IN FOR OUR COMMUNICATIONS THEN PLEASE CHECK AND SIGN THE FOLLOWING:

☐ I do not want to consent to Maui Urology's communication and records consent. I understand that by declining this free service, I may not receive notifications for appointments, lab results or other important notifications. I also understand that restricting access to my health records may impede or delay healthcare decisions by my health care providers.

____**Patient/Parent Signature** ________________________**Date**

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information up to date.

Maui Urology

Consent for Shared Information with Family and Friends:

☐ I wish specific family members or friends to have access to my healthcare information. Name(s) listed below are the people to whom I grant access to my healthcare information. I will rely on the professional judgment of my provider and his/her designee to share such information as they deem necessary. I understand that “sensitive” information as noted below will be excluded.

NAME	RELATIONSHIP
1) ______________________________	______________________________
2) ______________________________	______________________________
3) ______________________________	______________________________
4) ______________________________	______________________________

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information up to date.