

PERMISSION TO SHARE <u>LIMITED</u> HEALTH INFORMATION WITH FAMILY/FRIENDS

Patient Name D		DOB Accou	nnt or Med. Rec. #	
understand massist with m	his paper below, I give permission to the person by healthcare provider will use their profession by continuing care. Any information that does and HIPAA compliant authorization. This permission	nal judgment to ensure that i not pertain to assisting with	nformation is shared with my family/frien my health care and any copies of medical	d in order to
Date of Permission	Name of Individual & Relationship to Patient		ents/Instructions eds, may disclose test results, etc)	Patient/ Guardian Initials
THE PHYSIC	IANS/STAFF HAS MY PERMISSION TO: (Please			
	☐ Leave message at home with my spouse or:	NAME:		
		RELATIONSHIP:	DOB:	
	☐ Leave message on cell phone.	Cell phone number:		
☐ Leave message at work.		Work phone number:		
	☐ Leave a message on voicemail.	Phone number:		
	☐ Leave a detailed message on answering machine.	Phone number:		
		_		
Signature of Patient or Legal Guardian			Date	
Printed Name of Patient or Legal Guardian		_	Relationship (if not self)	