



**PERMISSION TO SHARE LIMITED HEALTH INFORMATION WITH FAMILY/FRIENDS**

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Account or Med. Rec. # \_\_\_\_\_

By signing this paper below, I give permission to the person(s) listed in the table documented to receive limited information about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friend in order to assist with my continuing care. Any information that does not pertain to assisting with my health care and any copies of medical records will require a signed HIPAA compliant authorization. This permission will be considered ongoing until I state in writing otherwise.

<b>Date of Permission</b>	<b>Name of Individual &amp; Relationship to Patient</b>	<b>Comments/Instructions</b> <i>(i.e.: may pick up meds, may disclose test results, etc)</i>	<b>Patient/ Guardian Initials</b>

**THE PHYSICIANS/STAFF HAS MY PERMISSION TO: (Please check all boxes that apply)**

- 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)*