HIPAA-Others Involved In Health Care

Patient Name: _____ Date of Birth: _____

As a patient of Providence Health & Services, would you like to elect to have others involved in your health care? Without your prior approval, we cannot discuss any medical information with family or friends. Please list the names of those you would like listed as being Involved in your health care. This information can be changed or revoked with your permission at any time.

I give permission for information related to my current health status to be discussed with:

Name	Relationship	Telephone
Name	Relationship	Telephone
Name	Relationship	Telephone
Name	Relationship	Telephone
Name	Relationship	Telephone

I understand that this might include such information as: diagnosis, prognosis and treatment plans, medications, discharge and instruction plans, diagnostic test results, appointment reminders, medical billing, insurance, and any other medical information relevant to my care.

_____ **Initial here to DECLINE to have medical information discussed with family or friends.**

Signature:_____ _____

Patient or Personal Representative Today's Date

Revised Date: May 2, 2009