Verbal communication with family and others involved in your care

Name:_____ Date of birth:_____

This form does not cover access to a release of medical records. This form may be used to document those individuals you want to communicate with providers and staff at Rose women's health, Inc., in person or on the phone, in regards to the coordination or payment of your care. For access to copy the records to one of the individuals you designate, you must complete an authorization for disclosure of protected health information for each separate disclosure or have an effective Advanced Healthcare Directive or other valid legal document on file.

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kind of information may be shared with each individual.

Name:	Relationship to patient:	Date of birth:	ALL	Schedule/ Appt.	Medical	Billing/ Insurance
			Initial	*Initial*	*Initial*	*Initial*
			Initial	*Initial*	*Initial*	*Initial*
			Initial	*Initial*	*Initial*	*Initial*
			Initial	*Initial*	*Initial*	*Initial*
			Initial	*Initial*	*Initial*	*Initial*
			Initial	*Initial*	*Initial*	*Initial*

Please describe any specific instructions or limitations:

_____

_____

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Please promptly notify your physician's office if you wish to alter the designations above.

Signature of patient or representative:_____ Date:_____

Relationship to patient:_____

To revoke this authorization, please send a written request with a copy of this form to the health information services department/release of information at the address below.

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