Permission to Share Limited Health Information with Family/Friends

Patient Name:______________________________ D.O.B____________ Med. Rec. #________________

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

Full name of the individual information may be released to	Relationship to patient	Information this person may have access to	Patient's initials
		check all that apply: ☐appointment scheduling ☐test results ☐pick up meds/prescriptions ☐pick up letters/correspondence ☐ALL medical information	
		check all that apply: ☐appointment scheduling ☐test results ☐pick up meds/prescriptions ☐pick up letters/correspondence ☐ALL medical information, including discussing healthcare with medical staff	

☐**DO NOT** release my health information to anyone

The Physician/Staff has my permission to leave a message on my answering machine regarding my care:

check all that apply:

☐Cell Phone (____)______________________

☐Home Phone (____)______________________

☐Work Phone (____)______________________

☐**DO NOT** leave any messages on my answering machine

______________________________________ ____________________

Signature of Patient or Legal Guardian Date

______________________________________ ____________________

Printed Name of Patient or Legal Guardian Relationship (if not self)