Office of Family Nurse Practitioner Laura Hudson FNP-C
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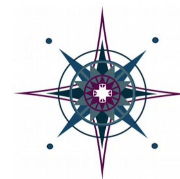

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

(Permission for Health Care Providers to Discuss Health Care with Providers, Family Members and Friends)

I allow my treating health care providers to discuss my health care with the individuals named below. These individuals play some role in my care, either by assisting me directly or by offering support to me and other family members.

I understand that this form does NOT give the individuals named below any authority to make health care decisions for me. It also does NOT allow them access to my medical records or documents.

This document is not a Health Care Power of Attorney. The sole purpose of this form is to protect my privacy by ensuring that my health care will be discussed **only with** individuals I have chosen.

I understand that I may designate as many individuals as I want, and *that I am not required to designate any such individuals.* I also understand that my health care providers may discuss my care with individuals not listed below if I give my verbal consent for such discussions to occur.

I understand that I may retract permission to share my information with anyone on this list as I have the right to fill out a new form that will supersede previous ones.

_______   I choose to authorize **NO ONE** at this time.

1.____ ________________________________

Name of Individual Authorized to Receive Information   Relationship

2.____ ________________________________

Name of Individual Authorized to Receive Information   Relationship

3.____ ________________________________

Name of Individual Authorized to Receive Information   Relationship

4.____ ________________________________

Name of Individual Authorized to Receive Information   Relationship

Patient Name ____ **DOB** ___________________

Signature Patient / Guardian ____________________________________ **Date** ___________________

Print Name of signer if not patient ______________________________ **Relationship**_______________