



Patient Communication and Sharing of Health Information

This information will help us communicate with you effectively and protect your privacy.

Patient Name: _____ **Date of Birth:** _____

Permission for Sharing Health Information

Please list the people with whom we can share your health information. No person automatically has the right to receive this information, including partners, children, etc. You should list below those people approved to share your health information, and also indicate individuals to exclude from sharing this information. While people not listed will generally not receive any information, listing a specific person to exclude further helps us protect your privacy. Under special circumstances, your providers may use best judgment in sharing your health information with others, and also must follow state and federal laws applicable to the disclosure of your health information.

Name	Relationship	O.K to Share Health Information?	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No

(If more space needed, indicate "continued" and attach additional copies of this form.)

Print Patient Name (and Authorized Representative if applicable)

Signature of Patient (or Authorized Representative)

Date