

Farr West Family Medicine

PERMISSION TO SHARE LIMITED HEALTH INFORMATION WITH FAMILY/FRIENDS

Patient Name _____ DOB _____ Account or Med. Rec. # _____

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

Date of Permission	Name of Individual & Relationship to Patient	Comments/Instructions <i>(i.e.: may pick up meds, may disclose test results, etc)</i>	Patient/ Guardian Initials

THE PHYSICIANS/STAFF HAS MY PERMISSION TO: (Please check all boxes that apply)

- Leave message at home with my spouse or:
 NAME: _____
RELATIONSHIP: _____ DOB: _____

- Leave message on cell phone. Cell phone number: _____
- Leave message at work. Work phone number: _____
- Leave a message on voicemail. Phone number: _____
- Leave a detailed message on answering machine. Phone number: _____

Signature of Patient or Legal Guardian

Date

Printed Name of Patient or Legal Guardian

Relationship *(if not self)*