Designation of Individuals who can discuss my care with my Healthcare Providers

Federal rules that our practice must follow protect the privacy and security of your health information. All the ways we use your health information and your rights under the Health Insurance Portability and Accountability Act, or HIPAA, are described in our Notice of Privacy Practices that you were offered when you first received care from us.

In the course of our providing care to you, you may wish to make it easier for us to speak with your family members and others who may assist your care. If you bring someone with you to your appointment and you bring them into the examination room with you, we consider that to be your consent to allow us to discuss your care in front of them. If you do not want them to be included in our discussion, please ask them not to come with you into the exam room. Sometimes your family members and others help you with your healthcare needs, if there is someone in particular you wish for us to be able to talk with about your healthcare needs, please complete this form and return it to reception. This will allow us to communicate with someone you trust about your care and treatment. The amount and type of information that will be shared about you with the person you designate is shared in the careful discretion of your healthcare provider. Examples of how we share your information include talking with you about your care in front of anyone you bring with you into the exam room, talking with your adult child designated on this form to help with your medical bills from your provider, and responding to questions about your medications with the person you designate.

If you wish for anyone to receive a copy of your medical records, a different form called an Authorization to Disclose Protected Health Information must also be signed by you.

This office has permission to disclose information regarding my medical care to the following specific person(s):

_____

This designation to share information to the individual(s) named above will remain in force until such time as I revoke it in writing.

I understand and have been provided with a Patient Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that this office reserves the right to change the notice and practices, but that prior to implementation, a copy of any revised notice will be provided.

I understand that I must revoke this consent in writing, except to the extent the organization has already taken action.

_____
Patient's Full Name

_____ _____
Signature of Patient or Legal Representative if minor Printed Name and Relationship to Patient

_____
Today's Date (Effective date of notice)