Disclosure to Friends and/or Family Members

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

1. Name: _____

   Relationship:_____

   Phone Number:_____

2. Name:_____

   Relationship:_____

   Phone Number:_____

3. Name:_____

   Relationship:_____

   Phone Number:_____

Patient Name (Print): _____

Patient Date of Birth: _____

Patient (or responsible party) Signature: _____

Date: _____

Expiration Date: _____

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Revised 7/18/17