HCA Physician Services
Terre Haute Heart Lung Vascular Associates

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 requested that does not pertain to assisting with my health care and any requests for copies of medical records will require a signed HIPPA 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.e.: may pick up meds, may disclose test results, etc)	**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:_____

In order to obtain information by telephone, the party calling the practice must be able to share the patient identifier/password with the staff.

Patient Chosen Identifier/Password:_____

_____ _____

Signature of Patient or Legal Guardian **Date**

_____ _____

Printed Name of Patient or Legal Guardian **Relationship *(if not self)***