Patient Name:

Patient DOB:

Who Can We Talk to About Your Care?

This form asks you to tell PCHC who, besides you, is involved in your care, so that PCHC may comfortably share information with them that is ***directly relevant*** to their involvement in your care or in payment for your care. Some examples of the type of information we would anticipate sharing with the people you list on this form include:

- ✓ dates and times of your upcoming appointments,
- ✓ your prescription refill information, dates or other medication information,
- ✓ your medication list,
- ✓ information about your lab results that is relevant to their involvement in your care, and
- ✓ the status of referrals or other care coordination issues relevant to their involvement in your care.

This form does *not* permit us to talk with anyone about substance abuse or mental health treatment, or about HIV/AIDS status or testing. To release that type of medical information about you to anyone, the law requires that we have a written authorization that specifically permits us to do that.

This form does not allow us to provide a copy of your medical records to the people listed below, or to anyone else, nor does it allow them to make any medical decisions for you.

I give PCHC staff permission to talk to the following people about my care:

Name of Person to Receive Information/Relationship to Patient (e.g., spouse, domestic partner, child, friend)/Phone Number

_____ /_____/ _____

_____ /_____/ _____

_____ /_____/ _____

This form will stay in effect for 30 months, unless revoked by you in writing before that time.

_____ ___/___/_____

Patient Name (PLEASE PRINT) **Today's Date**

_____

Patient's Signature (Parent or Legal Guardian signature, if a minor)

Revised 9/21/2016