Patient Label Here

GI ASSOCIATES ENDOSCOPY CENTER

DISCLOSURE TO FAMILY OR FOR NOTIFICATION

Purpose: This form is used to identify the family members, close friends, or other persons to whom we may disclose protected health information about you or notify regarding your care. This form is effective for the duration of your care or until you provide further notice.

INSTRUCTIONS – Please list the person (s) to whom protected health information about you may be disclosed regarding your treatment. Note, you must provide NAME and RELATIONSHIP.

Driver's Name: _____

Contact number: _____

Relationship to Patient: _____

Name: _____

Contact number: _____

Relationship to Patient: _____

PATIENT SIGNATURE

I attest that protected health information related to my care and treatment may be disclosed to the person (s) identified above.

_____ _____

Patient / Authorized Representative Signature Date / Time

If this Disclosure Form is signed by a Patient's Authorized Representative on behalf of the Patient, please complete the following:

_____ _____

Authorized Representative's Name Date / Time

_____

Relationship to Patient & Reason for Signing