A Northside Network Provider

English - Spanish

[OPTIONAL FORM – NOT REQUIRED TO BE COMPLETED]

Practice Name: _____

Name of Patient: _____ Phone #: _____

Address: _____ Patient's Date of Birth: _____

_____

Federal privacy regulations allow a health care provider, in certain limited circumstances, to discuss your health information, such as details about your care and treatment, with family members and close personal friends who are involved in your care. Depending on the circumstances, health care providers may be prevented from discussing your health information with someone who you might want them to. For that reason, some patients want to specifically authorize healthcare providers to engage in healthcare discussions with certain family members, friends, or other individuals. This form allows you to designate family members, friends or others with whom the practice listed above can communicate about your health care.

By signing below, you understand and acknowledge the following:

- The practice listed above is authorized to engage in discussion about your health care with the individuals listed on this form.
- This form does not restrict a healthcare provider from discussing your health information with individuals not listed on this form if such discussions are permitted by law.
- This form permits verbal communication only. This form does not allow the individuals listed below to obtain copies of your medical records.
- This form applies only to the practice listed above. If you receive health care from other Northside affiliated medical practices, you will need to complete a new form for each practice.
- This form is entirely voluntary and optional. Refusing to sign this form will not impact your care provided at this practice.
- Changes to this form must be made in person at the practice listed above.

This form can be revoked by submitting a written request to the Practice Manager of the Northside affiliated physician practice identified at the top of this form. You have the right to revoke this form in writing at any time except to the extent action has already been taken in reliance on it. The consent remains in effect until you revoke it in writing or sign a new form.

First and Last Name	Relationship	Phone Number

_____ _____

Witness Date/Time Signature of Patient or Legal Representative Date/Time

_____

Relationship to Patient If Not the Patient

_____ _____

Interpreter Signature Date/Time Reason Patient Unable to Sign

Note: If phone/video interpretation used, record interpreter ID#

Interpreter comments (optional): _____

_____

Please complete this form and return it to the Practice Manager

NORTHSIDE HOSPITAL PHYSICIAN OFFICE PRACTICE
CONSENT TO COMMUNICATE WITH DESIGNATED INDIVIDUALS