Clear Form Print

LOURDES

Label
or
Name DOB
MR#

Patient Preference Regarding Release of Health Information to Individuals Involved in Their Care or Family Members

Patient Name: (Please print)_____DOB:_____

_____ I do not want the Practice/Lourdes/my health care provider to release any information concerning my medical care to any individual involved in my care or to members of my family.

_____ The Practice/Lourdes/my health care provider or their staff may verbally release the following information concerning my medical care:

☐ Test results only ☐ Diagnosis only ☐ Any information concerning my medical care

☐ Other:_____

Individual(s) to whom the information may be released:

☐ Spouse _____
First Name Last Name Phone

☐ Son(s) / Daughter(s) _____
First Name(s) Last Name(s) Phone

_____
First Name(s) Last Name(s) Phone

☐ Step-Son(s) / Step-Daughter(s) _____
First Name(s) Last Name(s) Phone

_____
First Name(s) Last Name(s) Phone

☐ Significant Other _____
First Name Last Name Phone

☐ Other _____
First Name Last Name Phone

Relationship to patient:_____

This form will remain in effect until written notice to change is received.

_____ _____ _____
Patient Signature Date Time

_____ _____ _____
Witness Date Time

Re-Order # Net 057 5/23/12 PB001 2-h