Nepomuceno Hospital Group

Medical Disclosure

Facility: _____

Patient Name:_____

There are times it is necessary to share patient's health information with other healthcare providers who are involved in their care.

There are times when patient's health information will be requested family or friends. To protect the patient's privacy we need to know who we can discuss these matters with. If the patient cannot answer or sign this form then an appropriate designee will do so. Ideally this person is one who has been involved in the care and medical and legal decision making for the patient.

Please list all person you give permission disclose any of your health information, including test results, medications, or scheduling.

I, _____(patient or POA) give Nepomuceno Hospital Group and/

or staff permission to speak with the following persons regarding my medical care:

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Patient's or Power of Attorney/Designee Signature Date