College Park Family Care Center

ALL PATIENTS

Disclosures to Friends and/or Family Members

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below, if I am not available or they are acting on my behalf:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Above list remains valid until College Park is notified in writing of a change (s).

Print Name: _____DOB:_____

Patient signature: _____Date:_____

Staff use: Entered by:_____Date:_____