DESIGNATION OF CARE PROVIDERS FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION

Patient Name:_____

Address:_____

_____

Phone: (H)_____ (W)_____

I hereby request that me protected health information be communicated with others directly involved in my care. This designation of care providers will be kept as a permanent part of my medical record and will be copied as required in order to allow communication of my protected health information. I understand that my health care providers will use judgment in determining the minimum amount of information that must be shared in order to care for me.

I will inform my designated care providers of the last four digits of my social security number for identification purposes when inquiring about my health information.

DESIGNATION OF CARE PROVIDERS: (Specify name, relationship, agency, healthcare provider, etc. That will be allowed information as needed for your treatment)

_____

_____

_____

_____

_____

Signature:_____ Date:_____

Patient