Family, Friends, and Personal Representatives

Patient's Name: _____ Date of Birth:_____

Please use this form to identify anyone that may be transporting the patient to or from treatment or that may be in contact with our office regarding the patient's treatment. For each person listed, indicate whether we are authorized or not authorized to disclose personal health information (PHI).

☐ I do not have any friends, family, or personal representatives to list at this time.

Name: _____ Relationship: _____

Phone: _____ Disclose PHI: Y____ N____

Name: _____ Relationship: _____

Phone: _____ Disclose PHI: Y____ N____

Name: _____ Relationship: _____

Phone: _____ Disclose PHI: Y____ N____

Name: _____ Relationship: _____

Phone: _____ Disclose PHI: Y____ N____

Name: _____ Relationship: _____

Phone: _____ Disclose PHI: Y____ N____

Parent/Guardian Signature:_____ Date: _____