DISCLOSURES TO FAMILY, FRIENDS AND OTHERS INVOLVED IN HEALTH CARE OR PAYMENT

Except under emergency circumstances or if I am incapacitated, I agree that the Site **may share** my medical information with the individuals listed below who are involved in my care or payment for my care. If no names are provided by me or my personal representative, then I agree that my medical information could be shared with individuals who may be involved in my care or payment.

If you wish that no one receive my health information, mark “None” at the bottom of the form.

1. Spouse (name): _____
2. Children/Family Members (names): _____

   _____
3. Family or Others (names): _____

   _____

☐ None

Patient/Legal Representative Signature: _____

Print Name: _____

If not patient, Relationship of Legal Representative (parent, legal guardian):

_____

Date: _____

Date of Birth: _____