WENTWORTH HEALTH PARTNERS

Permission for Health Care Providers to Discuss my Health care with Family Members and Friends

Patient Name: _____ Patient Date of Birth: ____/____/_____
(Please print)

I allow the following treating Primary and/or Specialty providers:

☐ Primary Care Provider: _____ ☐ Specialty Care Provider: _____

☐ Specialty Care Provider: _____ ☐ Specialty Care Provider: _____

To discuss my health care with the individual(s) named below. These individuals play some role in my care, either by assisting me directly or by offering support to me and other family members. **I understand that this form does NOT give the individuals named below any authority to make health care decisions for me. It also does NOT allow them to access my medical record. This document is not a health care power of attorney.** The sole purpose of this form is to protect my privacy by ensuring that my health care will be discussed only with individuals I have chosen.

_____	_____	_____
Printed Name of Individual Authorized to Receive Information	Relationship	Phone Number
_____	_____	_____
Printed Name of Individual Authorized to Receive Information	Relationship	Phone Number

Please Note: *This authorization will expire 12 months from the date this form is signed. If I wish to continue this authorization after that date, a new form must be completed.*

_____ _____
Printed Name of Patient or Legal Representative/Guardian Date

_____
Signature of Patient or Legal Representative/Guardian

Revocation of Permission to Discuss my Health care with Family Members and Friends

I revoke all privileges of one or both of the following individual(s) _____/

_____effective: (Date) ___/___/_____

Patient Signature: _____

I understand that Wentworth Health Partners cannot take back any information that it shared when it had my permission to do so.