Others Involved in My Healthcare

Patient Name: ____

ID Number: _____________________________

Dr. Rinehart ***MAY discuss*** all aspects of my healthcare with:

_______________________________________ _____________________
Print Name Relationship

_______________________________________ _____________________
Print Name Relationship

_______________________________________ _____________________
Print Name Relationship

_______________________________________ _____________________
Print Name Relationship

As the patient, you may also request that any part of your Private Health Information (PHI) not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. Your doctor is not required to agree to a restriction that you may request. If your doctor believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If you doctor does not agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your doctor.

Dr. Rinehart ***MAY NOT*** discuss any aspect of my health care with the following person/people, unless it is needed to provide emergency treatment.

_______________________________________ _____________________
Print Name Relationship

_______________________________________ _____________________
Print Name Relationship

_______________________________________ _____________________
Print Name Relationship

_______________________________________ _____________________
Print Name Relationship

Date:____________________

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Signature of Patient or Legal Representative
(You have the right to rescind any part of this authorization with written notice.)

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