Specialists For Women
a division of mid atlantic womens care

DISCLOSURES TO FAMILY MEMBERS & FRIENDS

*Effective 10/16/03, applies to Specialists For Women

Patient Name: _____

Patient DOB: _____

Patient SSN: _____

I hereby agree that disclosures may be made to persons listed below as "Included" related to my Protected Health Information (PHI), or as needed concerning my account (i.e., payment for services rendered). I request that neither my PHI or account information be shared with persons listed below as "Excluded." I understand and acknowledge that in any case where this form is inaccessible, or in case of an emergency, that providers and/or staff will use their judgment in complying with my wishes herein.

CHECK ONE:		RELATIONSHIP	NAME
☐ Include	☐ Exclude		
☐ Include	☐ Exclude		
☐ Include	☐ Exclude		
☐ Include	☐ Exclude		
☐ Include	☐ Exclude		

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____