A Northside Network Provider

English - Spanish

[OPTIONAL FORM – NOT REQUIRED TO BE COMPLETED]

Name of Patient: _____ Phone #: _____

Address: _____ Patient's Date of Birth: _____

_____ Date:_____

As a patient, you have the option to designate a spouse, family members, friends, or other persons with whom this practice can communicate with about your health care status. It will be necessary to complete a new form at each Northside medical practice where you receive care. While this form is not required in all circumstances for your doctor or others at Northside to be able to communicate with your family about your health care, designating certain individuals who you want to be informed about your care on this form will ensure that your provider can speak with those people whom you have designated below.

If you anticipate that you will need or want your health information to be verbally provided to your family members, friends or caregivers, please indicate that below so that we may best serve you. By signing below, you authorize the following persons to receive your verbal health information as requested, regarding your care and treatment. Updates to this form must be made in person. Signing this form is entirely voluntary and optional. This form does not authorize release of copies of your health records.

First and Last Name	Relationship

I understand that this Consent can be revoked by submitting a written request to the Office Manager at the Northside Hospital Physician Office Practice identified at the top of this form. I understand that I have the right to revoke this Consent in writing at any time except to the extent that action has already been taken in reliance on it. This Consent shall remain in effect until the date I revoke it in writing or sign a new form.

_____ _____

Signature of Patient or Legal representative Print name

_____ AM/PM _____ _____

Date Time Relationship to patient

_____ _____

Interpreter (if applicable) Reason patient unable to sign

Note to staff: if telephone interpretation provided, record name of company and interpreter ID number.

Please complete this form and return it to the Practice manager.

FOR INTERNAL PURPOSES ONLY:

Date Consent Received:_____

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NORTHSIDE HOSPITAL PHYSICIAN OFFICE PRACTICE
CONSENT TO COMMUNICATE WITH DESIGNATED INDIVIDUALS

Original - Medical Records
Yellow - Patient