Permission to Discuss Protected Health Information with Family or Friends

Patient First Name _____ **Patient Last Name** _____

I give permission for We Care Nephrology to share the information checked below with the family and friends I have listed (check all that apply). This form does not authorize releasing copies of my records.

Options

☐ Scheduling Info ☐ Labs/Test Results ☐ Billing/Payment Info

☐ Medical info, including my symptoms, diagnosis, & medications ☐ Other (describe) _____

We Care Nephrology has my permission to discuss the above information with:

Name

Phone Number

Relationship

Name

Phone Number

Relationship

Name

Phone Number

Relationship

Name

Phone Number

Relationship

I understand that I have the right to revoke my permission at any time except where We Care Nephrology has already made disclosures in reliance upon this request. I understand this permission remains in effect until the time I revoke it in writing.

Patient/Legal Guardian Signature: _____

Date: _____