



94 Connecticut Boulevard
 East Hartford, Connecticut 06108
 F: 860-528-5180 Ph: 860-528-1359

PERMISSION TO SHARE **LIMITED** HEALTH INFORMATION WITH FAMILY/FRIENDS

Patient Name

DOB

Account Number

By signing this Permission to Share, I give permission to the person(s) listed below to receive limited information about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friends in order to assist with my continuing care. Any information requested that does not pertain to assisting with my health care and any requests for copies of medical records will require a signed HIPAA compliant authorization. This permission will be considered ongoing until I state in writing otherwise.

Name of Individual	Relationship to Patient	Information able to Share	Patient/Guardian Initials
		<input type="checkbox"/> Physical Health Info, Diagnosis, Medical/Dental Treatment, Lab Results <input type="checkbox"/> Substance Abuse Assessment, Diagnosis, and treatment related information <input type="checkbox"/> STD Diagnosis and treatment related information <input type="checkbox"/> Mental Health assessment, diagnosis and treatment related information <input type="checkbox"/> HIV/AIDS diagnosis and treatment related information	
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First Choice Health Centers, Inc. staff has my permission to: (Please check all boxes that apply)

Leave message at home with my spouse or: Name: _____ Relationship: _____ DOB _____

Leave message on cell phone. Cell Phone Number: _____

Leave message at work. Work Phone Number: _____

Leave a detailed message on voicemail. Phone Number: _____

 Signature of Patient or Legal Guardian

 Date

 Printed Name of Patient or Legal Guardian

 Date



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Permiso Para Compartir Informacion Medica Con Personas Especificas

Nombre del Paciente: «LastName», «FirstName» Fecha de Nacimiento: «DOB» Numero de Cuenta: «PatientAccountNumer»

Al Firmar este Permiso para compartir informacion, Yo le doy permiso a la persona o personas indicada en esta hoja que reciban informacion limitada sobre mi cuidado. Yo tengo el entendimiento que mi proveedor/es de salud, utilizaran su juicio profesional para asegurar la informacion compartida con mi familia o amistad/es para asistir con mi cuidado continuo. Otra informacion pedida que no pertenece a la asistencia de mi cuidado medico o pedidos del archivo medico requiere una firma de HIPPA dando authorization. Este permiso es considerado continuo has que yo de por escrito.

Table with 4 columns: Nombre del Individuo, Relacion al Paciente, Informacion que se puede compartir, and Iniciales del Paciente/guardian. It contains four rows of identical checkboxes for sharing medical information like lab results, substance abuse, STDs, mental health, HIV/AIDS, and financial info.

Los empleados de Frist Choice Health Centers, Inc. tienen mi permiso a: (Marque todas las cajas apropiadas.)

- Checkboxes for leaving messages with spouse (Name, Relationship, Date of Birth), on cell phone (Cellular Number), at work (Work Number), or detailed message (Telephone Number).

Firma del Paciente o Guardiante Legal _____ Fecha _____

Nombre del Paciente o Guardiante Legal _____ Fecha _____