CHICKAHOMINY FAMILY PRACTICE, INC.

Quinton & Providence Forge • PO Box 7 • Quinton • VA • 23141 • (804)932-4388 • Fax (804)804-932-9860

Disclosures to Family Members and Friends

Patient <u>does not</u> have to complete

☐ I, _____, authorize *Chickahominy Family Practice, Inc.* to disclose/discuss my private information relating to my health or as needed for payment of health care services to those listed below, if needed. I understand that only information relevant to my current treatment will be disclosed. I have agreed that *Chickahominy Family Practice, Inc.* may disclose health care information to: (check all that apply).

In person with patient	**By phone**	
_____	_____	**Spouse Name** _____
_____	_____	**Parent(s) Name**_____
_____	_____	**Sibling(s) Name**_____
		☐ **No One**
		☐☐ **Voicemail** ☐ **Other:**
		Relationship **Name**
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐ Although the patient was not available (or I could not discuss with the patient because of the patient's incapacity or an emergency circumstance), I felt that it was in the best interest of the patient to make a disclosure regarding the patient's health care status or payment for health care services to:

Name	**Relationship**	**Date of Disclosure**	**Comments(optional)**
_____			
_____			
_____			

Signature of Patient or Guarantor: _____

Date: _____ **Password (optional):** _____