

CHICKAHOMINY FAMILY PRACTICE, INC.

New Market Medical Center
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Fax (804)795-1052

Quinton Medical Center
1850 Pocahontas Trail
Quinton, VA 23141
Ph. (804)932-4388
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Providence Forge Medicare
9010 Pocahontas Trail
Providence Forge, VA 23140
Ph. (804)932-4388
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Disclosures to Family Members and Friends

Place on inside flap of medical record
Patient does not 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 _____
		<input type="checkbox"/> No One
		<input type="checkbox"/> Voicemail <input type="checkbox"/> Other:
		<u>Relationship</u> <u>Name</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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:

<u>Name</u>	<u>Relationship</u>	<u>Date of Disclosure</u>	<u>Comments(optional)</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Signature of Patient or Guarantor: _____

Date: _____

Password (optional): _____