Jefferson Healthcare

DESIGNATION OF RECIPIENT(S) FOR HEALTHCARE INFORMATION

Patient Name_____ DOB_____

Note: This form is used to provide advance permission for Jefferson Healthcare to discuss with or disclose protected health information to the persons listed below.

I hereby authorize Jefferson Healthcare to share information regarding my healthcare and treatment with the following:

PRIMARY Contact:

Name: _____ Relationship_____

Phone (s):_____

Address (if available): _____

☐ PT REP ☐ PCG ☐NOK ☐DPOAHC ☐DPOA ☐ EC ☐Other_____ ☐ Same Address as Patient

SECONDARY Contacts:

Name: _____ Relationship_____

Phone (s):_____

Address (if available):_____

☐ PT REP ☐ PCG ☐NOK ☐DPOAHC ☐DPOA ☐ EC ☐Other_____ ☐ Same Address as Patient

Name: _____ Relationship_____

Phone (s):_____

Address (if available):_____

☐ PT REP ☐ PCG ☐NOK ☐DPOAHC ☐DPOA ☐ EC ☐Other_____ ☐ Same Address as Patient

Add additional names on back

I wish to give my permission for Jefferson Healthcare Home Health and Hospice to share information with the person(s) designated above for the purpose of planning and implementing my healthcare.

I have been informed of my rights to privacy under HIPAA and make this request specifically to allow Jefferson Healthcare Home Health and Hospice to share information with the persons listed which would otherwise be protected.

Witness Signature_____ Date_____ Time_____

Witness Signature_____ Date_____ Time_____

(Witness may not be one of the persons designated a personal representative)

Patient Signature_____ Date _____ Time_____