



211 McAuley Court, Hot Springs, AR 71913 \* 205 McAuley Court, Hot Springs, AR 71913

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**PATIENT'S Permission for the Physician and his Staff to Discuss Protected Health Information with Others in the: Patient's "Circle of Care"**

Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Effective Date: \_\_\_\_\_

I do not grant the clinic's staff or physicians permission to discuss my protected health information and other personal information with anyone except as allowed by the HIPAA regulations, as explained in this agreement or as explained in the clinic's Notice of Privacy Practices which I have received.

I grant the clinic's staff or physicians permission to discuss my protected health information and other personal information with the following persons in my "circle of care" below:  
(List as many as you would like. List name of person, relationship and phone number.

**Name**

**Phone**

Spouse: \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Parent: \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Adult Children \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Sister/brother \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Other, specify name and relationship:

\_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Name Relationship

\_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Name Relationship

I understand that if I am not available or if, in the opinion of the physician, I am not able to comprehend information, treatment plans or instructions, the physician may determine it is in my best interest for him to talk to a person in my "circle of care", even though I have not given him written permission to do so.

I recognize that I can rescind this written permission and establish a new one at any time by contacting the clinic's privacy officer.

I have received/ or was offered a copy of the clinic's Notice of Privacy Practices.

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Date