211 McAuley Court
Hot Springs, AR 71913
800-794-5600 • 501-624-0609
501-624-6191 Fax

205 McAuley Court
Hot Springs, AR 71913
501-624-6330
www.holteye.com

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 and physicians permission to discuss my protected health information and other personal information with the following persons in my "circle of care":
Select as many as you would like. Enter the name on the line. If you know the phone number please enter that also.

	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 a copy of the clinic's Notice of Privacy Practices.

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Patient's signature Date