NORTHSIDE HOSPITAL, INC.

CONSENT TO COMMUNICATE WITH DESIGNATED FAMILY MEMBERS AND FRIENDS

Name of Patient: ______________________________

Address: ______________________________

____

Phone #: ______________________________

Patient's Date of Birth: ______________

Date: ______________________________

As a patient, you may designate a spouse, family members, friends, or other persons who Northside can communicate with about your health care status. While this form is not required in all circumstance for your doctor or others at Northside to be able to communicate with your family about your health care, designating certain individuals who you want to be informed about your care on this form will ensure that your provider can communicate with those people you have designated below without delay.

I, ______________________________,consent to have my health information and care discussed with the following people:

First and Last Name:	Relationship:

I understand that this Consent can be revoked by submitting a written request to the Office Manager at the Northside Hospital Physician Office Practice identified at the top of this form. I understand that I have the right to revoke this Consent in writing at any time except to the extent that action has already been taken in reliance on it. This Consent shall remain in effect until the date I revoke it in writing.

____
Signature of Patient or Legal representative

____
Print name:

____
Date

____
Relationship to patient::

____
Interpreter (if applicable)

Reason patient unable to sign: ______________________________

Note to staff: if telephone interpretation provided, record name of company and interpreter ID number.

Please complete this form and return it to the Practice manager.

FOR INTERNAL PURPOSES ONLY:

Date Consent Received: ______________

Original – Medical Records
Copy - Patient