



Permission for Disclosure to Family, Friends, and/or Caregivers

To the Patient:

I understand that patient health information is protected and confidential. With this understanding, I hereby grant the **High Plains Surgery Center** staff permission to discuss my health-related matters with family, friends, caregivers, or other designated persons, listed below.

Relevant health information may be shared with the following family members, other relatives, close personal friends, or other persons identified. Please print the name of person or persons who may receive this information and describe their relationship to you.

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

Disclosure UPDATED by patient:

Date and initial of patient: _____

_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Name: _____ **Date:** _____

Patient Signature: _____