Ascension
St. John Hospital
NEWLAND MEDICAL ASSOCIATES

Consent to Share Limited Medical Record Information

Protecting patient privacy is important to Ascension. We follow the HIPAA Rules for sharing your Protected Health Information, or PHI. We also want to support your wishes when it comes to sharing some of your health information with others involved in your care.

If you would like us to talk to and share some information about you with others, please list their name(s) and relationship to you below.

The type of information we would share includes but is not limited to appointment reminders, test results, care instructions, billing information, or prescription information.

*Please note, some Ascension locations share an electronic medical record. By completing this form, this means that someone you list below could be able to receive information about you from any Ascension location you are treated at. That includes any location(s) you have been to before, *but also any that you may go to in the future,* until and/or unless you complete a new form or tell us in writing that you no longer want the below listed person(s) to know your information. We will not release your medical records to these individuals unless you separately ask us to do so by submitting a separate valid authorization.

You are not required to list anyone, and you do not need to complete this form.

Ascension may share limited PHI as noted on this form with the following individuals:

Name: ____________________________ Relationship: ______________ Phone Number: ________________

Name: ____________________________ Relationship: ______________ Phone Number: ________________

Name: ____________________________ Relationship: ______________ Phone Number: ________________

By signing below:

- I am agreeing that Ascension may share my Protected Health Information (PHI) with the individuals listed.
- I understand that I can change my preferences by notifying Ascension in writing, but it will not have any effect on any information that was shared prior to the receipt of my change.
- I understand that this form does not allow anyone listed to make treatment decisions for me.
- I understand the information shared may include information about alcohol and drug abuse treatment, behavioral or mental health services, and/or communicable diseases and infections, such as sexually transmitted infections or HIV/AIDS. If I do not want this information shared, I understand I should not complete this form.

Patient Name (Printed): _____________________________ Date of Birth: ___________________

Signature: ____ Date: ________________________

If the person signing is not the patient, please print the name and type of authority to sign. Supporting documentation should be provided at the time of the request. ____