

## Disclosure to Family Members and Friends

Patient Name: \_\_\_\_\_

Patient Chart#: \_\_\_\_\_

It has been explained to me that information related to my health may be disclosed to my family and friends, or as needed for payment of health care services. I understand that Virginia Physicians for Women will only disclose information relevant to my current treatment. I agree that Virginia Physicians for Women may disclose health information to: (check all that apply)

Patient Signature: \_\_\_\_\_

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

In Person

With Patient

By Phone

Name (first, middle,last)

\_\_\_\_\_

\_\_\_\_\_

Spouse Name \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Parent(s) Name \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Sibling(s) Name \_\_\_\_\_

Other Persons

Relationship

Name (first, middle,last)

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**Please remember...It is your responsibility to keep this information current.**