Advocate Health Care

Discussing Health Information with Family or Caregivers

I would like the staff of Advocate Medical Group, Neurosurgery facility to discuss my protected health information and/or information related to payment for medical services received with the following named person or persons.

Patient Name: _____

Authorized Person: **(Primary contact)** _____

Contact Phone Number: _____

Relationship

Authorized Person: **(Secondary contact)** _____

Contact Phone Number: _____

Relationship

We ask that you limit the number of individuals able to receive your medical information by requesting only a primary and secondary contact.

All the above information must be confirmed prior to the verbal disclosure or release of any of your medical information, if we are unable to verify this information or have concerns regarding any release of information, we will limit the amount of information shared. If there is Highly Confidential information present in your medical information, release of this information requires your separate authorization and completion of the Advocate Release of Information Authorization form.

Signature of Patient **Date**

Note: If the patient is unable to make this decision

Signature of Parent or Legal Guardian for minors, or Legal Guardian or Authorized Representative under a Durable Power of Attorney for Adults **Date**