Chickahominy Family Practice, Inc.

New Market Medical Center
2660 New Market Rd
Richmond, VA 23231
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Fax (804)795-1052

New Kent Medical Center
1850 Pocahontas Trail
Quinton, VA 23141
Ph. (804)932-4388
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Providence Forge Medicare
9010 Pocahontas Trail
Providence Forge, VA 23140
Ph. (804)932-4388
Fax (804)966-9712

Disclosures to Family Members and Friends

Place on inside flap of medical record
Patient <u>does not</u> have to complete

☐ I, _____, authorize *Chickahominy Family Practice, Inc.* to disclose/discuss my private information relating to my health or as needed for payment of health care services to those listed below, if needed. I understand that only information relevant to my current treatment will be disclosed. I have agreed that *Chickahominy Family Practice, Inc.* may disclose health care information to: (check all that apply).

<u>In person with patient</u>	**<u>By phone</u>**	
_____	_____	**Spouse Name** _____
_____	_____	**Parent(s) Name**_____
_____	_____	**Sibling(s) Name**_____
		□ **No One**
		Voicemail **Other:**
		<u>Relationship</u> **<u>Name</u>**
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐ Although the patient was not available (or I could not discuss with the patient because of the patient's incapacity or an emergency circumstance), I felt that it was in the best interest of the patient to make a disclosure regarding the patient's health care status or payment for health care services to:

<u>Name</u>	**<u>Relationship</u>**	**Date of <u>Disclosure</u>**	**<u>Comments(optional)</u>**

Signature of Patient or Guarantor: _____

Date: _____ **Password (optional):** _____