First Choice Health Centers
For All Your Health Care Needs

94 Connecticut Boulevard
East Hartford, Connecticut 06108
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PERMISSION TO SHARE LIMITED HEALTH INFORMATION WITH FAMILY/FRIENDS

Patient Name DOB Account Number

By signing this Permission to Share, I give permission to the person(s) listed below to receive limited information about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friends in order to assist with my continuing care. Any information requested that does not pertain to assisting with my health care and any requests for copies of medical records will require a signed HIPAA compliant authorization. This permission will be considered ongoing until I state in writing otherwise.

Name of Individual	Relationship to Patient	Information able to Share	Patient/Guardian Initials
		☐ Physical Health Info, Diagnosis, Medical/Dental Treatment, Lab Results ☐ Substance Abuse Assessment, Diagnosis, and treatment related information ☐ STD Diagnosis and treatment related information ☐ Mental Health assessment, diagnosis and treatment related information ☐ HIV/AIDS diagnosis and treatment related information	
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		☐ Physical Health Info, Diagnosis, Medical/Dental Treatment, Lab Results ☐ Substance Abuse Assessment, Diagnosis, and treatment related information ☐ STD Diagnosis and treatment related information ☐ Mental Health assessment, diagnosis and treatment related information ☐ HIV/AIDS diagnosis and treatment related information	

First Choice Health Centers, Inc. staff has my permission to: (Please check all boxes that apply) ☐

☐ Leave message at home with my spouse or: Name: ____
Relationship: ___________________ DOB ___________

☐ Leave message on cell phone. Cell Phone Number: _____________________

☐ Leave message at work. Work Phone Number: ____________________

☐ Leave a detailed message on voicemail. Phone Number: _________________________

____ ____________________

Signature of Patient or Legal Guardian Date

____ ____________________

Printed Name of Patient or Legal Guardian Date