Isabella Citizens for Health, Inc.

Patient's Name: _____ **Birth Date**: _____/_____/_____

I have received the following documents and understand the policies outlined within. I have read the policies in their entirety and fully understand the information within relates to me and my family members. **(Please initial each line.)**

INITIAL: _____ General Consent for Treatment

INITIAL: _____ Patient and Center Rights and Responsibilities

INITIAL: _____ Missed Appointment Policy

INITIAL: _____ I acknowledge I have been offered or have received the **Notice of Privacy Practices** of Isabella Citizens for Health, Inc.

Release to Family and Friends Involved in Health Care

Isabella Citizens for Health has always been committed to the protection of your personal medical information. We realize that in today's society your spouse, individual family members, or close friends may be involved with your care or the payment of your care. In an effort to protect your personal medical information, we need to know the individuals you wish to allow our staff to release or discuss your care or the payment of your care with.

The physicians, nursing staff, and office staff have my permission to release or discuss my personal medical information concerning the following:

CHECK ANY THAT CAN BE RELEASED:

☐ General Medical Care ☐ Billing and Accounts ☐ Medications

☐ Insurance Information ☐ Appointments ☐ ALL Information

Isabella Citizens for Health may release or discuss my personal medical information, as indicated above, with any of the following individuals in person or by telephone.

1) _____ **Relationship:** _____

2) _____ **Relationship:** _____

3) _____ **Relationship:** _____

4) _____ **Relationship:** _____

Isabella Citizens for Health, Inc.

Release to Family and Friends Involved in Health Care continued:

_____	_____
Print Name of Patient	**Date**
_____	_____
Signature of Patient or Legal Representative	**State Relationship to Patient**
_____	_____
Signature of Witness	**Date**

Isabella Citizens for Health will not release or discuss your personal medical information with your spouse, individual family members, or close friends, as indicated above, for the following:

- Any information related to sexual abuse, child abuse, other abuse, neglect, or domestic violence.
- Any information that we feel may cause or bring harm to you or someone else.
- Any information related to pregnancy, infertility, sterilization, or other related topics.
- Any information related to sexually transmitted diseases.
- Any information related to Acquired Immunodeficiency Syndrome (AIDS), or human immunodeficiency virus (HIV)
- Any information related to alcohol or substance testing, treatment, or abuse.

If you desire our staff to release or discuss any of the above items with your spouse, individual family members, or close friends, you must specifically authorize, in writing, for us to do so. Any Isabella Citizens for Health staff member will assist you in doing so. This document shall remain in effect until revised or revoked by the patient or their personal representative.