LymphaTx

Approved List of Persons to Receive information of PHI

I agree that I have received and reviewed the Notice of Privacy Practices and understand the nature of the typical use and disclosure of my protected health information necessary for my health care treatment, billing for treatment provided, and for normal business operations.

I understand that it may be necessary to share my information in an emergency, or that I may wish family of friends to individuals be informed of my therapy situation. I also understand that the facility will provide that information only to those individuals who I have specifically listed below, or, should it be my wish, that no information be shared with any other individuals. Others may be added to or removed from the list of I so choose. Those named on the list will also be instructed about keeping my information private, and may be asked a confidential question to verify their identity before discussing my information.

These individuals may receive information regarding my health status, therapy situation, or other relevant medical details, and within the indicated level of disclosure:

Name	Relationship	Full or Partial Disclosure

For partial disclosure, please list any specific information not to be shared under any circumstances: _____

_____

_____ **It is my choice that no information be used or disclosed to any individuals outside the realm of the Privacy Practices unless discussed with me first.**

_____ _____

Patient or Personal Representative Signature Date

_____

Printed name of signatory

_____

Description of Personal Representative's Authority