CONTROLLED UNLESS PRINTED

# OTHERS INVOLVED IN HEALTHCARE

This form gives permission for Asante to verbally discuss information regarding medical treatment or condition, which may include protected health care information as defined below for:

☐ **Myself** Print Name: ________________________________________ Date of Birth: ________________________

☐ **My Dependent** Print Name:__________________________________ Date of Birth: ________________________

By checking these boxes, I am allowing this specific information to be *verbally shared* with the individuals I've chosen to participate in my care:

| | |
|---|---|
| ☐ **All Healthcare information outlined here** | ☐ Appointment Information (Includes date of appointment, time and length, provider being seen, and appointment preparation) |
| ☐ Diagnosis | ☐ Insurance/Reimbursement Information |
| ☐ Treatment | ☐ Account Billing Information |
| ☐ Lab Results | ☐ Other please specify):____________________________________________ |

**Please list the individuals you wish to participate in your or your dependent's care:**

| **Name of Person(s)** | **Relationship to Patient** |
|---|---|
| ______________________________________________ | ______________________________________________ |
| ______________________________________________ | ______________________________________________ |
| ______________________________________________ | ______________________________________________ |

[ ] I understand that this form does not permit the release of my medical records. All requests for medical records must be processed through the APP clinic or the Asante Medical Records Department with a written release of information authorization.

For **appointment information only**, as defined above, I request that Asante to send the information via:

[ ] Email (non-encrypted) **Note: I understand that not encrypting email increases the risk that information could be read by an unauthorized third party.**

[ ] Email (encrypted) **Note: Encrypted emails require a registration process upon receipt of the first email.**

Current Email Address: ________________________________________________

Patient's Signature: ____________________________________________ Date: __________________________

Parent/Legal Guardian's Signature: _________________________________Date: _________________________

***This form may be revoked upon request and/or updated as often as needed by completing a new form and will expire 365 days from date of signature.***

***Please return completed form to your clinic, hospital Medical Records Department or via email at roi@asante.org***

PATIENT STAMP