Middlesex Health

Outpatient Services / Office Visits
Patient Record of Disclosures

Notification of Disclosures to Persons Involved in Your Care

(This form may be used for all other hospital services and Off-site Locations.)

Patient Name:_____ **DOB:**_____

Permission to disclose information by telephone or by mail:

☐ No, I do not wish to have information via phone message or written communication.

☐ Yes, I wish to be contacted in the following manner:

Home #:	Work #:	Cellphone #:
☐ Leave a message with detailed information ☐ Leave a message with the call-back number only	☐ Leave a message with detailed information ☐ Leave a message with the call-back number only	☐ Leave a message with detailed information ☐ Leave a message with the call-back number only

☐ Written Communication
- ☐ Mail to my home address:_____
- ☐ Mail to my work/office address:_____
- ☐ Fax to this number:_____

☐ Other:_____

Permission to disclose information to family or other persons involved in your care

Unless you specifically agree, we will not disclose any information to family or other persons involved in your care either by phone or in person. This means, for example, that we will not be able to answer questions about a prescription, bill, schedule appointments or otherwise discuss your care or treatment with anyone other than you.

☐ No, I do not wish to have information shared with family or other persons involved in my care.

☐ Yes, I would like MHS to be able to discuss information related to my care with specific persons, listed below:

Name	Phone number	Relationship to Patient

_____ _____ _____
Signature of Patient or Personal Representative | Date | Time

_____
Relationship to Patient