Arthritis and Osteoporosis Medical Center

LIST OF PERSONS WE ARE AUTHORIZED TO SHARE YOUR MEDICAL INFORMATION WITH

Below, please list the names of anyone whom you give the Arthritis & Osteoporosis Medical Center permission to discuss or release your private health information to, and their relationship to you. (Can include, spouse, son, daughter, other physician, friend, etc.) **NO** changes will be made to this list unless a change request is submitted in writing and signed by you. (You can write in the back of this sheet if you need additional space)

Please check the appropriate box under each person's name.

If you check no please specify what information we are authorized to share with each of them.

Name **Relationship**

1. _____ _____

☐ **OK to share any and all information** ☐ **Only share certain information, Please Specify**_____
_____

Name **Relationship**

2. _____ _____

☐ **OK to share any and all information** ☐ **Only share certain information, Please Specify**_____
_____

Name **Relationship**

3. _____ _____

☐ **OK to share any and all information** ☐ **Only share certain information, Please Specify** _____
_____

NOTICE OF PRIVACY PRACTICES (HIPPA)

By signing below you acknowledge you were advised of the **Notice of Privacy Practices for ARTHRITIS AND OSTEOPOROSIS MEDICAL CENTER**. Our Notice of Privacy Practices provides information about how we may use and disclose your protected information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change. The Notice of Privacy is available on our website at **www.aomed.org**. You may also request a copy of the Notice of Privacy in our office.

_____ _____
Signature of Patient /Patient Representative Date

_____ _____
Name of Patient/ Patient Representative (please print) Relationship to Patient