

PRIVACY PRACTICES (HIPAA) INFORMATION

I have reviewed this privacy practices form and hereby acknowledge that I have been given and understand the privacy practices of Franklin County Memorial Hospital and Pool Medical Clinic.

By signing this form, I give permission to the above entities to discuss my medical condition with the following people.

Name(s) of person(s) – **PLEASE PRINT**

Spouse or Significant other: _____

Parents/Guardian: _____

Children: _____

Other Family Member(s): _____

Other: _____

Name of patient

Date of Birth

Signature

Date

Personal Representative

Date

REQUIRED: EMERGENCY CONTACT

Name

Phone Number