

## 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, Pool Medical Clinic

By 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): \_\_\_\_\_

Caregiver(s): \_\_\_\_\_

Close Personal Friend(s): \_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Personal Representative

\_\_\_\_\_  
Date