ENGLEWOOD HEALTH
PHYSICIAN NETWORK

DESIGNATION OF RELATIVES, FRIENDS, AND CAREGIVERS TO RECEIVE NECESSARY TREATMENT-RELATED INFORMATION

Patient Name: _____ **Date:** _____

Patient DOB: _____

I agree that Englewood Health Physician Network may disclose certain portions of my health information to a family member, close personal friend or other caregiver because such person is involved with my health care or payment relating to my health care.

Englewood Health Physician Network will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Signature of Patient/Guardian: _____ **Date:** _____

☐ I choose not to designate any individual at this time.

☐ I designate the following contacts listed below as persons involved with my health care or payment relating to my health care for Englewood Health Physician Network to make the limited disclosures described above.

I understand that I am not required to list anyone, and can change this list at any time in writing.

Contact Name: _____ **Contact's DOB (required):** _____

Relationship: _____

Contact Name: _____ **Contact's DOB (required):** _____

Relationship: _____

Contact Name: _____ **Contact's DOB (required):** _____

Relationship: _____