HOSPITAL

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO FAMILY AND FRIENDS

This form allows for the release of my protected health information to the family members and friends listed below during my stay at Holy Cross Hospital, and in a manner consistent with state and federal privacy laws. ***If I do not complete and sign this form, Holy Cross Hospital can only give the hospital room number, telephone number and my general health condition (i.e. excellent, good, fair, poor and critical) to people who ask for me by name.***

DISCLOSURE OF PROTECTED HEALTH INFORMATION:
I permit members of Holy Cross Hospital and the physicians to share my protected health information to the person(s) I list below for one or more of the following purpose(s): assisting with my health care needs, helping with the billing and payment process, informing my family members and friends regarding my health status or as requested by me. For each family member or friend you would like to receive protected health information, please print the name of that individual and check the boxes that apply.

Names of Family / Friend(s) (Please Print):	Protected Health Information Released:
1) _____	☐ All protected health information pertaining to my care ☐ Billing information ☐ Exceptions: _____
2) _____	☐ All protected health information pertaining to my care ☐ Billing information ☐ Exceptions: _____
3) _____	☐ All protected health information pertaining to my care ☐ Billing information ☐ Exceptions: _____
4) _____	☐ All protected health information pertaining to my care ☐ Billing information ☐ Exceptions: _____

YOUR RIGHTS:
I understand that I may refuse to sign this Authorization. If I do not complete this Authorization, it will not affect the use or disclosure of my protected health information for purposes of treatment, payment or eligible for benefits. I may inspect or copy my protected health information maintained by Holy Cross Hospital.

I understand that Holy Cross Hospital will not release my protected health information to others except as authorized by me or permitted by law. Once my protected health information is shared with a group or individual that is not required to follow federal privacy laws, Holy Cross Hospital cannot assure that the information will remain confidential.

OPT-OUT PROVISION:
I understand that I have the right not to be included in the Holy Cross Hospital Directory. If I elect to opt-out of the Directory, then no information will be available to any person(s) inquiring about my admission to Holy Cross Hospital. **Opt-Out: YES____ NO ____**

EXPIRATION:
This Authorization is in effect until the date I am discharged from Holy Cross Hospital unless I otherwise indicate on the line provided: _____. I can change my mind at any time and revoke my permission to allow my protected health information to be disclosed to any family or friend(s), except to the extent that Holy Cross Hospital has relied on this Authorization.

If I have any questions regarding this Authorization, I may contact the ***Hospital Privacy Official*** at:

(301)

Signature of Patient or Representative	Date	Relationship to Patient