** PHI ACCESS FORM**

**Family, Friends, and Others Involved in Your Care**

**Her Choice Midwifery Services** prides itself in the close relationship that we have with our patients. But we may not be sure, in every case, whether a family member or friend is involved in your care. We ask that you complete this form to inform us of those individuals. We will enter this information in our computer system to assist our staff in verifying a person’s involvement. By identifying your caregivers, you can avoid problems that may arise when our staff does not know a person’s relationships to you and your care. This form does not address individuals who are involved in the payment to your health care services, such as guarantors.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Address:

By completing this form and signing below you are granting **Her Choice Midwifery Services** permission to share protect health information(PHI) including without limitation, appointment information, test results, diagnosis, or treatment plans, with the individual(s) listed below who is/are a family member, close friend, or other person involved in your care. Under certain medical circumstances, however, a licensed health care professional may identify one or more individuals after determining his/her professional judgment that sharing PHI on a continual basis would be in the best interest of that patient (e.g. emergency situation, no power of attorney was granted to the caregiver, etc.). There may be other medical situations where the practice may disclose PHI to family members or friends in accordance with federal and state law. Categories of people will not be accepted (e.g. “All family members” or “all members of your church”) because of the difficulty in verifying their identity.

NAME RELATIONSHIP ADDRESS AND PHONE NUMBER