PATIENT HEALTH INFORMATION REQUEST FORM

At which of the following number(s) do we have permission to contact you?

☐ Home ______________________________ ☐ Work ____________________________

☐ Cell Phone __________________________ ☐ Other ______________________________

May we leave a message for you: at work? ☐ Yes ☐ No at home? ☐ Yes ☐ No cell? ☐ Yes ☐ No

Other than you or your insurance, whom may we talk to about your healthcare information?

NAME	PHONE NUMBER	RELATIONSHIP

In order to verify accurate health and surgical information, we will be asking you various questions in different settings. The Pre-Op Holding Area and Post-Anesthesia Area are locations where you and other patients will be asked questions. You will be in separate bays within these areas, and you may be seen or overheard by other patients/family members. Will this be a problem for you? ☐ Yes ☐ No

Do you have any health information that you would like kept confidential from any person or persons?

☐ Yes ☐ No ☐ If so, please describe:
____

_______ I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information. I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information

_______ I understand that by designating this individual as my support person/patient representative, I am hereby giving permission to share my protected health information with the designated individual.

Would you like to designate a support person/patient representative? ☐ Yes ☐ No

If yes, list name of designated individual: ____

- Your support person/patient representative may remain with you throughout your hospital stay, with the following exceptions:
  - During a treatment or procedure
  - In a medical emergency, at the physician's discretion
  -
- You also have the right to receive visitors throughout your hospital stay. North Central Surgical Center's Post Surgical Unit has an open visitation policy, as long as visitors are not disruptive to other patients. If there is anyone you would like to restrict from visiting you, please let us know.

x____

Patient/Patient Representative Signature Date Time