CapitalCare

A division of Community Care Physicians, PC

Permission to share protected health information for coordination of care

CapitalCare's health professionals, using their best judgment, may disclose health-related information to a relative, close personal friend or any other person you identify as being involved in your care. Please provide us with the names of those individuals who are involved with your care, with whom we may share your protected health information to coordinate your care.

(In the event that you are a parent or legal guardian of a child treated by CapitalCare, please provide us with the names of those individuals who are involved with the child's care, with whom we may share your protected health information to coordinate the child's care.)

Name of individual	Relationship	Telephone
Name of individual	Relationship	Telephone
Name of individual	Relationship	Telephone
Name of individual	Relationship	Telephone

I understand that if I wish to revoke permission to release protected health information to any or all of these individuals, it will be my obligation to notify CapitalCare of this decision.

Patient's name (print):_____ DOB ____/____/_____

Signature of patient/parent/legal guardian:_____

If other than patient, please indicate relationship/authority:_____

Date of signature:_____ Expiration date:_____

Revised: 05/16/2018