Holland Hospital

Sharing of Protected Health Information

Patient's Name:_____ Date of Birth_____

Patient confidentiality is important to us and we will only share protected health information with family and friends that you give us written permission to verbally share information with. If there are people involved in your care who should be able to receive verbal information about your health, your testing or your treatment, including appointment dates and times, please print the names below.

Name	Phone number	Relationship

Please print the names of all adult individuals involved in the care of a minor child or adult individual under the guardianship of another adult.

Name	Phone number	Relationship

Please note: All patients will receive appointment reminders and messages from the physician via phone call, text, or patient portal. Please indicate your preferred order of preference by numbering your selections 1st/2nd/3rd.

Phone/Preferred number_____	Text/Preferred number_____	Patient Portal (email address)_____

The signature below confirms your understanding and permission to verbally share the information you have provided in this document.

Patient or Legal Guardian Signature:_____ Date:_____