SSMHealth
Medical Group

PATIENT INFORMATION (PLEASE PRINT CLEARLY)

Legal Name of Patient _____ Birth Date_____/_____/_____
(Last) (First) (MI)

Age: _____ Gender: Male Female Gender Identity: _____

Social Security #: _____/_____/_____

Home Address: _____
(Street) (City) (State) (Zip)

Mailing Address: _____
(Street) (City) (State) (Zip)

Phone in order of preference: 1)_____ 2)_____ 3) _____
☐Home ☐Cell ☐Work ☐Home ☐Cell ☐Work ☐Home ☐Cell ☐Work

E-mail address:_____

Preferred language: _____ Need interpreter: ☐Yes ☐No

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Other Religion_____

Ethnicity: ☐Hispanic or Latino Origin ☐Not Hispanic or Latino Origin Race_____

Allowed Communication: ☐ Do not Contact ☐ Mail ☐ Phone ☐ MyChart Primary Care Physician: _____

Referring Physician: _____ Phone #: _____

Emergency Contact: _____ Home Phone # (____)_____
(Name) (Emergency Contact)

Relationship to Patient: _____ Cell Phone # (____)_____
(Emergency Contact)

Patient Employer: _____ Work Phone#:_____ Ext. _____

Custodial Parent: _____ Birth Date:_____/_____/_____ SSN#____/___/_____
(If Patient is Child) (Name)

Address: _____City: _____ State: _____ Zip:_____

Home #: (___) _____ Employer: _____Wk Phone #: (___) _____ Ext: _____

Is this a work related injury or illness? ☐Yes ☐No **If yes, please provide worker's comp information below.**

Insurance Information: ***We will need a copy of the insurance card in order to file a claim.***

Primary Insurance Coverage: _____Policy #: _____

Group #: _____**Insured Name:** _____

Male Female Unknown DOB: _____ SSN#:_____

Relationship to Patient:_____ **Primary Insured Employer:** _____

Secondary Insurance Coverage: _____Policy #: _____

Group #: _____Insured Name: _____

Male Female Unknown DOB: _____ SSN#:_____

Relationship to Patient:_____ Primary Insured Employer: _____

Third Insurance Coverage: _____Policy #: _____

Group #: _____Insured Name: _____

Male Female Unknown DOB: _____ SSN#:_____

Relationship to Patient:_____ Primary Insured Employer: _____

I authorize SSM Health Medical Group, including any collection agency or debt collector hired by SSM Health Medical Group to check my credit and employment history, obtain a copy of my consumer report and obtain personal information from any consumer reporting agency or any other person or entity in possession of such information. I also authorize SSM Health Medical Group, or through its contracted debt collection of amounts owed for said services, using an automatic telephone dialing system or prerecorded voice at the telephone number(s) I provided, including a telephone number assigned by a cellular telephone service or any service for which I am charged for the call. In addition, I consent to and agree that any call between SSM Health Medical Group and I may be monitored and/or recorded for any purpose.

Patient/Custodial parent Signature:
I hereby apply for treatment by the physicians of this practice and or their assistants. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf and I assign the benefits payable to which I am entitled to this practice. I understand that payment is due at the time of service and that I am financially responsible for all charges, whether or not paid by insurance.

Signature: _____ **Date:** _____/_____/_____

Notice of Privacy Practices **Effective Date: July 10, 2015**

This Notice of Privacy Practices ("Notice") serves as a notice for all SSM Health entities providing health care services (such SSM Health entities referred to collectively as "we" or "our"). **This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this Notice carefully.** If you have any questions about this Notice, please contact a registration representative at the hospital, physician's clinic or other SSM Health entity where you are receiving health care services.

Who Will Follow This Notice
This Notice applies to our workforce members, including employees, volunteers, students and trainees. This Notice also applies to other health care and service providers that provide care or services at our facilities, or for our patients, in that, as a condition to providing services at our facilities, such providers must agree to comply with our policies, including our policies relating to patient privacy. This Notice, however, only details our privacy policies and does not govern the independent practices or operations of health care and service providers, such as the privacy practices that your doctor, if not employed by us, may use in his or her private office.

Our Pledge Regarding Medical Information
We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the health care services you receive from us. We need this record to provide you with quality health care services and to comply with certain legal requirements. This Notice applies to all of the records of your care that we generate.
We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this Notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the Notice that is currently in effect.

How We May Use and Disclose Medical Information About You:
The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories:

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, health care students, clergy, or others who are involved in your health care services. For example, your medical information may be shared with a physician to whom you have been referred in order to ensure that the physician has the necessary information to diagnose or treat you. We also may use your medical information to coordinate the different things you need, such as prescriptions, lab work and x-rays. If you are in one of our facilities, we also may disclose medical information about you to people outside the facility who may be involved in your medical care after you leave our facility.

For Payment: We may use and disclose medical information about you so that the treatment and services we provided to you may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about your treatment so they can pay us or reimburse you. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations: We may use and disclose medical information about you to improve our services or support our business activities. For example, we may use medical information to review our treatment and services, to evaluate the performance of our staff in caring for you. We may also disclose information to doctors, nurses, technicians, health care students, and or other personnel for review and learning purposes. We or our designee may send you a patient satisfaction survey via mail or to an email address that you provided to us. Specific individual information will not be included in the email without authentication of a specific patient identifier to access the survey.

Notice: SSM Health, Dean Health Systems and Dean Health Plan are part of an Organized Health Care Arrangement (OCHA). As part of the OHCA, we may from time to time share your information with other members of the OHCA in order to perform joint health care operations. For example, we may share your information in order to; improve population health management, conduct quality assessment and improvement activities; conduct or arrange medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general OHCA Administrative activities.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment with us or to notify you that it's time for you to schedule a medical service with us.

Treatment Alternatives: We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services: We may use and disclose medical information to tell you about health related benefits, services, or education resources, such as screenings, seminars, classes, or other programs that may be of interest and beneficial to you.

Fundraising Activities: We may use information about you to contact you in an effort to raise money for our operations. For this purpose, we may use your name, address and phone number, the dates you received treatment or services and the department in which you received those services. If you do not want to be contacted for fundraising efforts, you will be given the opportunity to notify the appropriate Privacy Officer in writing.

Patient Assistance Programs: We may use and disclose your information to third parties for the purpose of determining whether you qualify for a private or government patient assistance program that would reduce the amount you owe to SSM.

Hospital Directory: If you are receiving health care services in one of our hospitals, unless you advise the registration representative otherwise, we may include certain limited information about you in the hospital directory while you are a patient at the hospital. This information may include your name, location in the hospital, your general condition (e.g., good, fair, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name. This is so your family, friends and clergy can visit you in the hospital and generally know how you are doing. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may share medical information about you to a care giver who may be a friend or family member. We may also give information to someone who helps pay for your care. If you are unable to object to such a disclosure, we may discuss your medical information with a family member, friend, or other person if, using professional judgment, we conclude that you do not object. Only the medical information that is relevant to your care will be disclosed.

Research: Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process.

As Required By Law: We will disclose medical information about you when required to do so by federal, state or local law.

Special Situations:
Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military: If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation: Under Federal or State law, we may be required to provide copies of your medical information in connection with a workers' compensation claim to your employer, to you or your dependents, to certain state agencies or to others involved in your claim for compensation.

Public Health Risks (Health and Safety to you and/or others): We may disclose medical information about you for public health activities. We may use and disclose medical information about you to agencies when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person or when we are legally required to do so. These activities generally include the following:

– To prevent or control disease, injury or disability;

– To report births and deaths;

– To report child abuse or neglect;

– To report reactions to medications or problems with products;

– To notify people of recalls of products they may be using;

– To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition

– To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure when required or authorized by law.

Health Oversight Activities: We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute.

Law Enforcement: To the extent permitted by law, we may release medical information if asked to do so by a law enforcement official. We may release medial information when we are legally permitted to do so:

– In response to a court order, subpoena, warrant, summons or similar process;

– To identify or locate a suspect, fugitive, material witness, or missing person;

– About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;

– About a death we believe may be the result of criminal conduct;

– About criminal conduct at one of our facilities; and

– In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors: We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities: We may release medical information about you to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Other uses of Medical Information: Most uses and disclosures of psychotherapy notes, uses and disclosures of medical information for marketing purposes and certain disclosures that constitute a sale of your medical information will require your written permission. Additionally, other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Your Rights Regarding Medical Information About You
You have the following rights regarding medical information we maintain about you:

– To inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but may not include all psychotherapy notes.

– Request in writing to inspect and copy medical information that may be used to make decisions about you. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

– We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that another licensed health care professional chosen by us review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you have the right to request in writing that we amend the information by providing the reason for the amendment. You have the right to request an amendment for as long as the information is kept by or for us.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

– Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

– Is not part of the medical information kept by or for us;

– Is not part of the information which you would be permitted to inspect and copy; or

– Is accurate and complete.

If we deny your request for an amendment, we will do so in writing and you have the right to file a statement of disagreement.

Right to an Accounting of Disclosures: You have the right to request in writing an "accounting of disclosures." This is a list of the disclosures we made of medical information about you to others, excepting disclosures relating to treatment, payment and health care operations.

Your request must state a time period which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, or; electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Receive Notice of Breaches: You have the right to receive notifications of breaches of your unsecured medical information.

Right to Request Restrictions, in General: You have the right to request in writing a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery performed.

– We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Restrictions to a Health Plan: You have the right to request in writing a restriction or limitation on the medical information we disclose about you to a health plan for purposes of payment or health care operations if you, or someone on your behalf, has paid for the health care item or service out of pocket in full.

– If you, or someone on your behalf, has paid for the health care item or service out of pocket in full, we are required to agree to your request if the disclosure to the health plan relates to payment or health care operations.

In your request, you must tell us (1) the name of the health plan that is not to receive the disclosure; (2) what health care item or service you wish to restrict from disclosure; (3) the location in which the health care item or service was provided to you; and (4) the date the health care item or service was provided to you.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

Please advise the registration representative how or where you wish to be contacted. We will not ask you the reason for your request. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time by requesting a copy from the registration representative.

Changes to this Notice:
We reserve the right to change this Notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in our facilities and this Notice will be available on the SSM Health Care website. The Notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register at or are admitted as a patient, you have the right to request a copy of the current Notice in effect.

Questions about this Notice or Complaints:
If you have questions about this Notice or if you believe your privacy rights have been violated, you may contact the SSM Health Privacy/HIPAA Contact at (314) 994-7724. While we will make every effort to resolve any complaints, please know that you also have the right to file a written complaint with the Secretary of the Department of Health and Human Services. The quality of your care will not be jeopardized nor will you be penalized for filing a complaint.

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Medical Group

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I hereby acknowledge that I received a copy of this medical facility's Notice of Privacy Practices which describes how my protected health information may be used and disclosed, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Printed Name of Patient _____DOB_____

Signature of Patient _____

Date _____

Printed Name of Personal Representative _____

Signature of Personal Representative_____

Date _____

Description of Authority of Personal Representative _____

_____

FOR OFFICE USE ONLY:
All medical offices will make a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual. If the patient (or personal representative) is unwilling and or unable to sign this acknowledgement, the facility must document its good faith efforts to obtain such acknowledgement and record the reason why the acknowledgement was not obtained.

To be completed by medical facility if unable to obtain written acknowledgement from the patient.

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices from this patient, but it could not be obtained because:

[ ] The patient refused to sign.
[ ] Due to an emergency situation, it was not possible to obtain an acknowledgement.
[ ] We were not able to communicate with the patient.
[ ] Other (Please provide specific details) _____

_____

Does patient have a copy of the Privacy Notice?
[ ] Yes **[ ]** No

_____

Employee Name Date

Scan in Patient Chart

SSMHealth

OUR MISSION:
Through our exceptional health care services, we reveal the healing presence of God.

PATIENT RIGHTS:
As our patient, we have the responsibility to respect, protect, and promote your rights. You are a key member of your Health Care Team and you have the right to:

- Receive safe, quality care through the services that the hospital provides.
- Receive care and have visitation privileges without being discriminated against because of age, race, color, national origin, language, religion, culture, disability, sex, gender identity or expression, sexual orientation, or ability to pay.
- Choose who can and cannot visit you, without regard to legal relationship, race, color, national origin, religion, sex, sexual orientation, gender identity or disability. You may withdraw or deny consent for visitation at any time.
- Be informed when the hospital restricts your visitation rights for your health or safety, or the health or safety of patients, employees, physicians or visitors.
- Be informed of the hospital's policies about your rights and health care.
- Be treated with respect and dignity and be protected from abuse, neglect, exploitation and harassment.
- Have your own physician and/or a family member, support person, or other individual be notified promptly of your admission to the hospital.
- Know the names and roles of hospital staff caring for you.
- Have a family member, support person, or other individual present with you for emotional support during the course of your stay, unless the individual's presence infringes on others' rights, safety, or is medically or therapeutically contraindicated.
- Have a family member, support person, or other individual involved in treatment decisions or make health care decisions for you, to the extent permitted by law.
- Have an Advance Directive (health care directive, durable power of attorney for health care, or living will) that states your wishes and values for health care decisions when you cannot speak for yourself.
- Be informed about your health problems, treatment options, and likely or unanticipated outcomes so you can take part in developing, implementing and revising your plan of care and discharge planning. Discharge planning includes deciding about care options, choice of agencies or need to transfer to another facility.
- Have information about the outcome of your care, including unanticipated outcomes.
- Request, accept and/or refuse care, treatment or services as allowed by hospital policy and the law, and be informed of the medical consequences of your refusal of care.
- Ask for a change of care provider or a second opinion.
- Have information provided to you in a manner that meets your needs and is tailored to your age, preferred language, and ability to understand.
- Have access to an interpreter and/or translation services to help you understand medical and financial information.
- Have your pain assessed and managed.
- Have privacy and confidentiality when you are receiving care.
- Practice and seek advice about your cultural, spiritual and ethical beliefs, as long as this does not interfere with the well being of others.
- Request religious and spiritual services.
- Request a consult from the Ethics Committee to help you work through difficult decisions about your care.
- Consent or refuse to take part in research studies as well as recordings, films or other images made for external use.
- Be free from restraints or seclusion, unless medically necessary or needed to keep you or others safe. If necessary, any form of restraint or seclusion will be performed in accordance with safety standards required by state and federal law.
- Have a safe environment, including zero tolerance for violence, and the right to use your clothes and personal items in a reasonably protected environment.
- Take part in decisions about restricting visitors, mail or phone calls.
- Receive protective oversight while a patient in the hospital, and receive a list of patient advocacy services (such as protective services, guardianship, etc.).
- Receive compassionate care at the end of life.
- Donate, request or refuse organ and tissue donations.
- Review your medical record and receive answers to questions you may have about it. You may request amendments to your record and may obtain copies as permitted by law at a fair cost in a reasonable time frame.
- Have your records kept confidential; they will only be shared with your caregivers and those who can legally see them. You may request information on who has received your record.
- Receive a copy of and details about your bill.
- Ask about and be informed of business relationships among payors, hospitals, educational institutions, and other health care providers that may affect your care.
- Submit a concern regarding your care. The hospital maintains a grievance process for the resolution of concerns, which you may submit directly to us. You

should expect to receive a timely verbal or written response, as requested or otherwise required by law and policy. If you have a concern, please contact your care provider or the manager of the patient care area where you are receiving care.

- Request electronic versions of your medical record, if the medical record is maintained electronically.
- Opt-out of fundraising.
- Restrict certain disclosures of PHI to a health plan if the patient has paid out of pocket for a health care item or service.
- You may also contact:

Oklahoma State Health Department
Attention: Medical Facilities Department
1000 NE 10th Street, Oklahoma City, OK 73104
405-271-6576

The Joint Commission
Office of Quality and Patient Safety
1 Renaissance Blvd., Oakbrook Terrace, IL 60181
Email: complaint@jointcommission.org
Fax: 1-630-792-5636
Complaint Line: 1-800-994-6610

Ohio KEPRO Medicare QIO Services
Rock Run Center
5700 Lombardo Center Drive, Suite 100 Seven Hills, OH 44131
Beneficiary Helpline, toll-free: 1-888-315-0636

PATIENT RESPONSIBILITIES

You and/or your family member, support person, or other designated individual acting on your behalf have the responsibility to:

- Provide correct and complete information about yourself and your health, including present complaints, past health problems and hospital visits, medications you have taken and are taking (including prescriptions, over-the-counter and herbal medicines), and any other information you think your caregivers need to know.
- Follow your agreed-upon care plan and report any unexpected changes in your condition to your doctor.
- Ask questions when you do not understand your care, treatment, and services or what you are expected to do. Express any concerns about your ability to follow your proposed care plan or course of care, treatment, and services.
- Accept consequences for the outcomes if you do not follow the care, treatment, and service plan.
- Speak up and share your views about your care or service needs and expectations, including your pain needs and any perceived risk or safety issues.
- Provide correct and complete information about your Advance Directive if you have one and provide a current copy.
- Respect the rights, property, privacy, dignity, and confidentiality of patients and others in the hospital.
- Be respectful in your interactions with other patients, employees, physicians and visitors without regard to age, race, color, national origin, language, religion, culture, disability, socioeconomic status, sex, gender identity or expression, or sexual orientation.
- Follow instructions, hospital policies, rules and regulations which include respecting property and helping control noise.
- Leave your valuables and personal belongings at home, have your family members take them home, or have them placed with Security until you are discharged.
- Keep our environment tobacco-free. You may not use any tobacco products while inside or outside this health care facility.
- Keep a safe environment free of drugs, alcohol, weapons, and violence of any kind, including verbal intimidation.
- Provide correct and complete information about your financial status as best you can and promptly meet any financial obligations to the hospital.
- For more information about your Patient Rights and Responsibilities, please contact the Team Leader of the patient care area where you are receiving care.

_____
Patient Signature

_____
Date / Time

SSM Health
Medical Group

VERIFICATION FOR TELEPHONIC and/or VERBAL COMMUNICATIONS

It is the intent of SSM Health Medical Group and our staff to provide you exceptional care. Our physician organization strives to keep your health information confidential and protected while sharing one common electronic health record. Family, friends and others involved in your care may call one or more of our provider's office(s) to inquire about your health information. To maintain confidentiality, it is best to designate the individual(s) you grant SSM Health Medical Group and/or their staff permission to share your health information with, including but not limited to lab results, x-ray/imaging results, or other information pertaining to your care.

I give my permission to SSM Health Medical Group, its group providers and/or staff to discuss my health conditions such as lab results, test results, or other information pertaining to my health care, with the following designated persons on the list below. I understand this could result in unintended disclosure of health information.

Check all that apply:

_____Spouse Name:_____

_____Child Name:_____

_____Child Name:_____

_____Child Name:_____

_____Other:_____

_____Other:_____

My signature indicates that I have read the above and grant the request. I understand that if I do not sign, or list any person, the information will not be given to anyone but me. I also understand that I am able to revoke this authorization at any time and the request must be in writing. I further understand this verification is inclusive to the SSM Health Medical Group and staff members. I understand that it is my responsibility to provide written notice of changes to the list stated above.

Patient Name_____

Patient Signature_____

Date _____