SSMHealth
In partnership with the Felician Sisters
Medical Group

Sharing Health Information

Please Print:

First Name MI Last Name Date of Birth

Please identify below how you would prefer us to communicate with you by placing an "X" next to the appropriate box and provide needed addresses or phone numbers and CIRCLE your first communication choice:

Cell Phone #:		**Written Communication:**		**Electronic Communication:**	
	Leave message with detailed information		Mail to:		MyChart: Send message with detailed information
	Leave message with call back number only		Fax to:		E-Mail to:
Work Telephone #:		**Home Telephone #:**		**Other (list below):**	
	Leave message with detailed information		Leave message with detailed information		
	Leave message with call back number only		Leave message with call back number only		

Unless you object, SSM Health Medical Group may share or discuss information about you to a care giver or someone who helps pay for your care (friend or family member). Your provider will determine what information about you needs to be shared based on a need to know basis.

Please identify below family members or others involved in your care or payment that we may share information with:

Name	Relationship	Phone Number

In addition, your health information may be shared if:

- You are present and do not object to sharing the information to others that are with you (example: your medical information regarding medications is discussed in front of your sister that you brought in the exam room with you).
- You give your provider or plan permission to share the information.
- You are not present, and the provider determines based on professional judgment that it is in your best interest (examples: in case of an emergency, or a care giver calls and requests the dosage of a medication you are taking).

We will follow the above information unless notified by you in writing. This document does not apply to disclosure of specific mental health care information governed by the states Mental Health Code and Confidentiality Act.

Signature of Patient / Parent or Legal Guardian Date