ASHLAND
FAMILY PRACTICE

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# Third-Party Disclosure

**Today's Date:**_____

**Patient Name:**_____ **Birthdate:**_____

**Do you have a Power of Attorney?** ☐ Yes ☐ No
If yes, please provide us with the following information and all related forms:

Name:_____ Phone #:_____

Relationship:_____

Address: _____ City: _____ State:_____ Zip:_____

**Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health operations.)**

| Name | Phone # | Relationship |
|---|---|---|
| | | |
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**Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:**

| Name | Phone # | Relationship |
|---|---|---|
| | | |
| | | |
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| | | |

**Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voicemail?**

☐ Home ☐ Cell ☐ Work ☐ No Messages

**Patient Signature:**_____ **(Guardian if under 18)**

**Date:**_____