UPSTATE
UNIVERSITY HEALTH SYSTEM

PERMISSION TO DISCUSS CONFIDENTIAL HEALTH INFORMATION

Patient Name: ______________________ MR#: ______________

Account #: ______________ DOB: __________ Date: __________

This form must be completed if you wish to grant Upstate University Hospital and affiliated private practices permission to discuss confidential health information about your care with family members, friends, and others involved in your care who may inquire. As explained in our 'Notice of Privacy Practices', we must provide you with the opportunity to agree or object before we can discuss some of your confidential health information with family and friends who are not making healthcare decisions on your behalf. If you wish to designate one or two individuals with whom we can discuss your confidential health information, please use the space below to indicate their name(s). It is important that you be made aware of the following before granting such permission:

- The information we are permitted to discuss with the individuals you name is limited to general care and treatment information and will not include information that is given greater protection under law such as HIV-related information, mental health information, substance abuse treatment information, genetic information, or any other information that your healthcare provider determines, in the exercise of professional judgment, could be of a sensitive nature.
- The individuals you name below must give us their name, and may be asked to give us your date of birth, when they inquire before we can discuss any information with them. If the inquiry is made in person, we may ask the individual for photo identification.
- If you are receiving outpatient services you will be asked to review and renew this permission yearly.
- If you are the personal representative giving permission on behalf of the patient, this form will expire if the patient becomes capable of making their own healthcare decisions.

This permission can be revoked at any time by sending a letter to the Institutional Privacy Administrator at 750 East Adams St., Syracuse, New York 13210.

I give my permission to Upstate University Hospital and affiliated private practices* to discuss my confidential health information with the following individuals (PLEASE PRINT):

1. Name: ______________ Telephone #: ______________ Relationship: ______________
2. Name: ______________ Telephone #: ______________ Relationship: ______________

Patient Signature: ______________ Date: ______________

Personal Representative's Name ______________ Signature: ______________

Staff Witness: ______________ Date: ______________

*Specify Outpatient Service: ______________