CONSNT

CoxHealth
Springfield, MO

Patient Sticker

PERMISSION TO SHARE INFORMATION

Please <u>print</u> information below:

- I, _____ authorize CoxHealth to share VERBAL information about my care and treatment to the person (s) specified below.
- I realize this does NOT authorize the person (s) below to make health care decisions for me.
- I further understand that this DOES NOT permit the person(s) listed below to view or receive copies of my medical record.
- I realize I can modify this form at any time by speaking with my nurse, while hospitalized. After discharge, I can revoke this form by submitting a written request to the Corporate Privacy Officer at 3801 South National Avenue.
- I realize, in the case of an emergency situation where CoxHealth determines that a limited disclosure may be in my best interest, CoxHealth may share limited protected health information with others who may be involved in my care.
- In special security situations, we may ask your designated contacts to provide a picture ID.
- We ask that you limit your designated contact people to three individuals so we can spend our time caring for the patient.

NAME	PHONE	RELATIONSHIP TO PATIENT
_____	_____	_____
_____	_____	_____
_____	_____	_____

Specific Instructions or Limitations:

_____

Signature of Patient: _____ Date:_____

Legal Representative: _____ Date: _____

Relationship to Patient: _____

This form may be revoked by your signature below:

Patient:_____ Date:_____ Time:_____