HOPE
CANCER CENTER
OF EAST TEXAS
Expertise. Experience. Compassion. HOPE.

PATIENT RECORD OF DISCLOSURE

I understand that it is the policy of HOPE Cancer Center of East Texas to restrict access to my Protected Health Information. In addition to the caregiver(s) providing health services, and my insurance company/companies for payment of my claims, I would like the following person/people to have access to my Private Health Information.

CONTACT NAME	RELATIONSHIP	CONTACT TELEPHONE #	DATE OF BIRTH	ACCESS TO INFORMATION
1. *John / Jane Doe*	*Spouse*	*999-999-9999*	*01/01/1900*	◯ All or ◯ Restricted*
2.				◯ All or ◯ Restricted*
3.				◯ All or ◯ Restricted*
4.				◯ All or ◯ Restricted*
5.				◯ All or ◯ Restricted*

* Clinical Info Restricted – If you checked this box above, please specify what clinical information you **DO NOT** wish to share with the person(s) listed above:

◯ Sexually Transmitted Disease(s)
◯ Pregnancy
◯ Terminal Illness
◯ Mental/Behavioral Health
◯ Other _____

Communication:

You **MAY** or **MAY NOT** leave confidential clinical information on my answering machine. (Circle one)

_____ Patient Signature

_____ E-mail Address **(REQUIRED)**

_____ Patient Name (Printed)

_____ Date of Birth

_____ Witnessed By

_____ Date

State law permits both parents to have access to PHI unless we are provided a court order restricting this right.