Authorization People Involved In Patient's Care

I have the right to choose family members, friends or others to be involved in talks about my health care. The people listed below may receive any verbal information needed to be involved in my care or to help me make decisions about my care. By signing this form, I give permission for staff within West Michigan Foot and Ankle PLLC to discuss information about me with the people listed. The information discussed may include diagnosis, test results, medicine, treatment options and other information from previous services I have had, either in hospitals or other locations.

- I know that information may be discussed with family members or others without this form, if allowed by federal and state laws.
- I know that listing a person on this form does not allow them to get or copy my medical records.
- People listed on this form are not allowed to give consent for services for me.
- For a minor, parents are assumed to be designated except for those services which the minor has given consent under Michigan Law.

LIST PEOPLE THAT MAY RECEIVE VERBAL INFORMATION ABOUT YOUR CARE:

Name of Person	Relationship	Contact Phone Number(s)	Allowed To Receive Verbal Information About Your Care
			☐
			☐
			☐

The following information has special protection under Michigan Law and will be made available to the people listed above ONLY if I give my approval by checking the box(es) below AND initial the line(s).

_____ ⬜ HIV/AIDS or other diseases - Tuberculosis, hepatitis, venereal diseases, sexually transmitted diseases.
_____ ⬜ Substance abuse services
_____ ⬜ Mental Health Services

I can update this form at any time by telling a WMFA staff member AND by filling out a new form. I can take away my permission to share my information at any time by putting that request in writing and giving that request to a WMFA staff member.

Patient Signature(s)
I have read this form and I understand it. All my questions have been answered.

TIME: _____ ⬜AM/⬜PM **DATE:** _____ **SIGNATURE:** _____

IF YOU ARE A PARENT/LEGAL GUARDIAN/PATIENT ADVOCATE/ NEXT OF KIN SIGNING FOR THE PATIENT:

PRINTED NAME OF PARENT/LEGAL GUARDIAN/PATIENT ADVOCATE/ NEXT OF KIN: _____

RELATIONSHIP TO PATIENT: _____

⬜ I wish to receive E-mail communications ⬜ I wish to receive text communications