

Disclosures to Family Members and Friends

It has been explained to me that disclosures may be made to family and friends related to the patient's health or as needed for payment of healthcare services. It has been explained that Vascular Surgery Associates will only disclose information relevant to current treatment. I agree that Vascular Surgery Associates may disclose healthcare information to : (fill in all that apply)

Relationship:	Name:	Telephone #
Spouse	_____	_____
Parents	_____	_____
Siblings	_____	_____
Adult Children	_____	_____
Others	_____	_____

****Staff will not make disclosures to any family member or friend not listed above.****

Patient's signature

Date