Jefferson University Physicians

JUP Communication of Protected Health Information

Patient Name: _____ Date of Birth: _____
(Please Print)

MRN: _____

Part A

You have informed Jefferson University Physicians (JUP) that in certain circumstances, you would like us to share your medical information with specified individuals (e.g., your spouse, mother, etc.).

JUP agrees to communicate with persons whom you designate regarding your protected health information. This agreement will remain in effect unless you provide us with written notice to terminate this consent.

Part B

I hereby grant Jefferson University Physician's department/division of

_____

permission to communicate my protected health information to the following individuals:

Name:	Relationship:
Address:	Telephone #:

Name:	Relationship:
Address:	Telephone #:

Name:	Relationship:
Address:	Telephone #:

Name:	Relationship:
Address:	Telephone #:

Patient Signature: _____ Date: _____

Witness: _____ Date: _____