PINE CREEK
MEDICAL CENTER

PERMISSION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
PINE CREEK MEDICAL CENTER - FACILITY DIRECTORY

I am exercising my right to permit or prohibit inclusion of my Protected Health Information (PHI) in a Directory of Patients maintained by Pine Creek Medical Center throughout the course of this admission.

(Check the box below that applies and sign at the bottom of the page)

❑ I do not wish to be listed in the Pine Creek Medical Center Facility Directory.

❑ I do wish to be listed in the Pine Creek Medical Center Facility Directory and I agree that my name, location in PCMC, brief description of my condition, and a religious affiliation (accessible to clergy members **only**) can be included in PCMC Facility Directory.

Signature: _____ Date: _____

Printed Name: _____

Relationship if not Patient: _____

Patient's Date of Birth: _____ Patient's SS#: _____

Patient's Address: _____

If option communicated orally by Patient, recorded by:

Signature: _____ Date: _____

Printed Name: _____ Phone: _____

Department/Title: _____