



PERMISSION TO USE AND DISCLOSE PROTECTED
HEALTH INFORMATION
PCMC- 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 Directory
- I do wish to be listed in PCMC Directory and I agree that my name, location in PCMC, brief description of my condition, and a religious affiliation (accessible only to clergy members) can be included in PCMC Directory.

Signature: _____ Date: _____

Printed Name: _____

Relationship if not Patient: _____

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

Patients Address: _____

If option communicated orally by patient, recorded by:

Signature: _____ Date: _____

Printed Name: _____ Phone: _____

Department/Title: _____