

Peninsula Kidney Associates

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Williamsburg, Virginia 23188

**Notice of Privacy Practices
Disclosure of Family Members and Friends**

Patients Name: _____

I have explained to the patient, _____ that disclosures may be made to family and friends related to the patient's health. I have explained that we will only disclose information relevant to current treatment. Our patient has agreed that we may disclose health care information to: (check all that apply)

_____ Spouse's Name: _____

_____ Parent(s) Name: _____

_____ Sibling(s) Name: _____

Other: Name: _____ Relationship _____

Patient Signature: _____ Date: _____

Office Use Only

Employee's Signature

Date

Although permission could not be obtained from the patient, a situation arose where making disclosure regarding the patient's health care status on an urgent basis in the best interest of the patient to:

Name

Relationship

Date

Comments

Employee Signature and Date

For Office Use:

MR #: _____