MinnesotaHospice
THE GOLD STANDARD of Care

HIPAA

Client Name: ________________________________

While recognizing that every patient has family members and friends who are concerned about them and who wish to see how they are doing, we must protect the privacy of our clients as mandated under the Privacy Act of 1996. **Please list below the names and contact information of anyone you wish to allow Minnesota Hospice to speak to about your care or to disclose health information to.**

Name ________________________________ Relationship ________________
Address ____
City ____________________________ State __________ Zip ____________
Phone number (h) ____________________ (c) ______________ (w) ______________
E-mail address ______________________________

Name ________________________________ Relationship ________________
Address ____
City ____________________________ State __________ Zip ____________
Phone number (h) ____________________ (c) ______________ (w) ______________
E-mail address ______________________________

Name ________________________________ Relationship ________________
Address ____
City ____________________________ State __________ Zip ____________
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Phone number (h) ____________________ (c) ______________ (w) ______________
E-mail address ______________________________

Name ________________________________ Relationship ________________
Address ____
City ____________________________ State __________ Zip ____________
Phone number (h) ____________________ (c) ______________ (w) ______________
E-mail address ______________________________

Use reverse side of this document if additional entries are required.

I hereby verify that all of the individuals listed above may obtain information from the Minnesota Hospice team.

________________________________ ________________
Patient/Legal Representative Date

________________________________ ________________
Minnesota Hospice Representative Date