MinnesotaHospice
THE GOLD STANDARD of Care

Patient: _____ DOB: _____

HIPAA - HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT*

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 Patients 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) _____
E-mail _____

Name _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Phone number (h) _____ (c) _____
E-mail _____

Name _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Phone number (h) _____ (c) _____
E-mail (h) _____

Name _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Phone number (h) _____ (c) _____
E-mail (h) _____

Name _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Phone number (h) _____ (c) _____
E-mail (h) _____

Name _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Phone number (h) _____ (c) _____
E-mail (h) _____

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/Authorized Representative Signature _____ Date _____

Minnesota Hospice Representative Signature _____ Date _____

*Route to Facility