



**DISCLOSURES TO FAMILY MEMBERS & FRIENDS**

PATIENT'S NAME \_\_\_\_\_

Date of Birth \_\_\_\_\_ OR Last Four of Social \_\_\_\_\_

This Notice is effective as of January 1, 2016 and applies to Neurology Associates of Suffolk, PLLC.

I hereby agree that disclosures may be made to family and friends (listed below as "Included") related to my health or as needed for payment of healthcare services. I also request my information not be shared with persons listed below as "Excluded". I also understand that in cases where this form is not accessible or in cases of emergency, the Physicians and Staff may use their best judgment in complying with my designation of healthcare and account information.

<u>(Circle One)</u>	<u>Relationship</u>	<u>Name</u>
Include - Exclude	_____	_____
Include - Exclude	_____	_____
Include - Exclude	_____	_____
Include - Exclude	_____	_____
Include - Exclude	_____	_____
Include - Exclude	_____	_____

\_\_\_\_\_  
Signature of Patient or Legal Representative Date

If signed by Legal Representative, state Relationship to Patient \_\_\_\_\_

