

**PATIENT PREFERENCE REGARDING COMMUNICATION OF HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ MR#: \_\_\_\_\_

I hereby give permission to the Baylor Martha Foster Lung Care Center to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_ I do not wish to give permission for additional family members, relatives, or close personal friends to have access to any information regarding my medical condition(s).

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information for persons not listed above will require a specific authorization prior to the disclosure of any medical information.

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

\_\_\_\_\_  
Date

Legend:

**BAYLOR UNIVERSITY MEDICAL CENTER**  
DALLAS, TEXAS



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