Designation of Certain Relatives, Close Friends and Other Caregivers:

I agree that Ocean Pulmonary Associates may disclose my health information to a designated family member, close personal friend or other caregiver, since such person is involved with my health care or payment relating to my health care. In that case, Ocean Pulmonary Associates will disclose only information that is directly relevant to the person's involvement with my health care. I wish to be contacted in the following manner (check all that apply):

__OK to leave message with detailed information at my home/cell number: (___) _____

__on my answering machine

__with anyone answering the phone

__with my significant other

__Leave a message with call back numbers only

__Leave a detailed message

__Ok to email. Email Address: _____

__Ok to text to my cell phone number: (___) _____

I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of Ocean Pulmonary Associates making the limited disclosures described above I understand that I am not required to list anyone. I also understand that I may change this at any time in writing. I understand that I may change this at any time in writing. I understand that Ocean Pulmonary Associates will not disclose health information to any person not designated except in case of an emergency.

Name: _____ DOB (required as identifier) _____

Name: _____ DOB (required as identifier)_____

Name: _____ DOB (required as identifier)_____

Signature: _____ Print: _____Date:_____