

## PATIENT'S RIGHT TO AGREE TO INCLUSION OR OPT OUT FORM

Questions to patient requiring a response to appropriately maintain their privacy:

1. Do you wish for us, in the course of your care at PPM, to release information regarding you and your health to: (please circle your answer).

- A family member  Yes  No

Names: (please print)

1. \_\_\_\_\_

2. \_\_\_\_\_

- Other Relative  Yes  No

Names: (please print)

1. \_\_\_\_\_

2. \_\_\_\_\_

- Close Personal Friend(s)  Yes  No

Names: (please print)

1. \_\_\_\_\_

2. \_\_\_\_\_

- Personal representative identified by you. If yes, please identify by name:

1. \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please print your name: \_\_\_\_\_