Family Members and Friends Involved in Patient Care
Novi Ophthalmology, PC

This form documents my request to allow family members and/or friends to be involved in **verbal** discussions regarding my health care. The people listed below may receive any **verbal** information needed to participate in my care or to help me make decisions. By signing this form, I permit staff at Novi Ophthalmology, PC to discuss information about me with the people listed below. This information may include diagnosis, test results, treatment options and other information from previous services.

- I understand that signing this form is voluntary and that information may be released to family members or others without this form, if allowed by federal and state law.
- I understand that listing people on this form does not give them the right to receive or copy my medical records.
- It does not allow them to consent for health care services on my behalf.
- I understand this form is NOT to be used to request a restriction on my information.

Name	Phone	Relationship

The following information has special protection under Michigan law and will be made available to the people I have listed above only if I indicate my approval by initialing the line(s) below:

_____HIV/AIDS or other communicable disease including sexually transmitted diseases, venereal disease, tuberculosis, and hepatitis

_____Substance abuse services

_____Mental health services

I can update this form at any time by completing a new form and either giving it to my provider or sending it to 26850 Providence Parkway, Suite 360 Novi, MI 48374 (Fax: 888-443-3187). I can revoke or cancel this form at any time by sending written notification to the same address or fax. This form does not expire unless revoked or updated.

_____ _____

Signature of Patient or Legally Authorized Representative (if patient is unable to sign) Date (mm/dd/yyyy)

_____

Printed Name of Legally Authorized Representative (proof of power of attorney or legal guardian required)

Relationship:_____