Mary Marshall, MD

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Family and Friends Involved in Patient Care

This form documents my request to allow family members and/or friends to be involved in verbal discussions regarding my healthcare. 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 within Dr. Marshall & Rye's office to discuss information about me including: diagnoses, test results, and treatment options with the individuals listed below.

- 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 or state law.
- I understand that listing a person on this form does not give them the right to receive or copy my written medical records. It does not allow them to consent to healthcare services on my behalf.
- I understand this form is not used to share information about patients who are minors.

Name	Phone	Relationship

The following information has special protection under Michigan law and will be made available to the people I've listed above **only if I indicate my approval by initializing the line(s).**

_____ HIV/AIDS or other communicable diseases 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 giving it to my provider. I can revoke this form at any time by sending written notification to Dr. Marshall & Rye's office. **This form does not give the people listed above the right to directly access my medical information by using any information technology system within Dr. Marshall & Rye's practice.**

Signature:_____ Print Name:_____
Date:_____

☐ Relationship to patient:
☐ Legal representative/guardian (Proof of POA/ legal guardianship required.)