rgoa ROCHESTER GYNECOLOGIC AND OBSTETRIC ASSOCIATES, P.C.

David L. Gandell, M.D.
Stephan R. Sanko, M.D.
Diane M. Cunningham, M.D.
Deborah M. Rib, M.D.
Georgette J. Pulli, M.D.
Mary E. Ciranni-Callon, D.O.
Julie C. Sandruck, M.D.
Nancy E. McKnight, M.D.
Mitchell A. Linder, M.D.

PATIENT'S REQUEST TO AUTHORIZE USE/DISCLOSURE OF PHI TO A FAMILY MEMBER/FRIEND

1. **Authorization – Use or Disclosure.** I request that the Practice allow the use or disclosure of my protected health information ("PHI") described below when carrying out my treatment, or obtaining payment for my treatment, or when carrying out the Practice's health care operations. The restriction requested is described below.

   DESCRIPTION OF INFORMATION TO BE DISCLOSED:_____

   _____

2. **Restriction – Family Member/Friend.** I request that the Practice restrict the disclosure of my PHI so that **only** the family member, other relative or close personal friend herein named who is involved with my care or the payment for my care **may have access to my PHI (Please Print):**

   _____

   _____

   _____

3. **Practice Response.** I understand that the Practice is not required to agree to the restrictions that I have requested.

4. **Termination.** I understand that the Practice may agree to a restriction and may also, in the future, terminate its agreement, but such termination will only be effective with respect to PHI created or received after I have been notified of the termination.

_____ _____ _____
Name of Individual (Printed) Date of Birth Signature of Individual

_____
Patient's Address (number and street, city, state, zip)

_____ _____
Signature of Personal Representative Relationship (e.g., Attorney-In-Fact, Guardian, Parent if a minor)

Date Signed _____/_____/_____ Witness: _____

(Rev. 11/14)