

## **Change in HIPAA Status Center for Family Wellness, PA**

### **EXCLUSIONS**

I want to exclude the disclosure of any of my health information to the following providers, individuals, organizations, hospitals, and/or insurance companies. (Excluding an insurance company would preclude our filing insurance on your behalf).

### **INCLUSIONS**

I want to allow the disclosure of any of my health information to the following individuals, organizations and hospitals. (Note you do not need to include insurance companies or providers as they are automatically included and can only be excluded)

\_\_\_\_\_  
Patient Name (printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Authorized Provider Representative

\_\_\_\_\_  
Personal Representative (printed)

\_\_\_\_\_  
Personal Representative Signature

\_\_\_\_\_  
Description of personal representative's authority to act for the patient.