ZABRECKY
INSTITUTE of Biomedicine

Spouse/Family Information Disclosure

I,_____ _____/_____/_____
(Print Name) (Date of Birth)

Request the following restrictions to the use or disclosure of my protected information.

Zabrecky Institute of Biomedicine may discuss my medical condition/information with the following people:

Please circle YES or NO and print in the appropriate person's name.

Spouse:	YES	NO	Name:_____
Parents:	YES	NO	Name:_____
	YES	NO	Name:_____
Children:	YES	NO	Name:_____
	YES	NO	Name:_____
	YES	NO	Name:_____
	YES	NO	Name:_____
Significant Other:	YES	NO	Name:_____
	YES	NO	Name:_____
	YES	NO	Name:_____

Patient Signature:_____ Date:_____

789 E. Lancaster Ave. | Suite 230 | Villanova, PA 19085 office: 610-616-2500 fax: 610-616-2525
www.ZabreckyInstitute.com