

I have had the opportun			
i nave nau the opportun	ity to receive a copy of Jefferson	n Community Health and Life Hospital/C	linic's Notice of Privacy
Practices. I understand t	hat JCHL has the right to change	e its Notice of Privacy Practices from tim	e to time and that I may
contact JCHL at any time	e to obtain a current copy of the	Notice of Privacy Practices.	
Patient Name (please pr	 int)		Date of Birth
ration Name (picase pr	iiic)		Date of Birth
INDIVIDUALS INVOLVED	IN PATIENT CARE OR PAYMEN	ІТ	
Jefferson Community He	ealth and Life Hospital/Clinic ma	y disclose your relevant medical inform	ation to family members
or others you designate	who are involved in your care o	r payment for your care, we ask each pa	ntient to designate in
writing those individuals	who may receive information r	elating to your medical care or paymen	t at JCH&L. For example,
we may give lab or othe	r test results by phone to such ir	ndividuals when you are not available.	
DECIGNATION OF INDIV	WD11416 4 DDD0\/FD TO DE651\/	- 44501641 (41500444-1041	
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	-	ion regarding my care, or payment for n	ny care at Jefferson
Community Health and I	ле ноѕрітаў сіпіс		
☐ BILLING INFOR	RMATION ONLY	☐ I WISH TO MAKE NO DESIGNAT	ION AT THIS TIME
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I understand that I must	update this form if my circumst	tances or preferences change.	
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Date

Patient/Representative Signature