marin community clinics

PLACE STICKER HERE

NAME_____

DOB_____

PERMISSION TO SHARE MEDICAL / DENTAL INFORMATION WITH FAMILY, FRIENDS AND CAREGIVER (FOR ADULTS)

FROM:

Patient Name: _____ Birth Date:_____

With your permission we may share relevant information (protected health information) with family members, friends and caregivers involved in your healthcare, in certain circumstances.

I give permission for the person listed below to access my private health information:

□ Spouse	□ Family member	□ Friend	□ Caregiver

TO: Print Name:_____

This person can (INITIAL all permissions you want to give):

_____Make or cancel appointments for me

_____Talk to my doctor / dentist or other health center staff on my behalf

_____Handle my paperwork, routine labs, and prescriptions

_____See my complete medical and financial records (*Behavioral Health Records, STD, HIV, Alcohol and Substance Abuse require provider sign-off)

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I may change this at any time by signing a new form. MCC retains the right to withhold medical information at your provider discretion.

Patient Signature: _____Date:_____