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

_______Bring in or pick up my paperwork

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

☐ Spouse	☐ Family member	☐ Friend	☐ Caregiver

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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

_______ Bring in or pick up my paperwork

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:__________________