Patient Request for Sharing of Treatment/Billing Information with Family/Friends

I, _____, _____, request that _____
Patient's Name *Birthdate* *Practice Name*

share my individually identifiable health information with the following individuals:

Name of person(s) and/or organization	Relationship	Phone Number
Name of person(s) and/or organization	Relationship	Phone Number
Name of person(s) and/or organization	Relationship	Phone Number
Name of person(s) and/or organization	Relationship	Phone Number

Please note that minimal information such as request for return phone calls and appointment reminders are permitted without express consent. In addition, your provider may choose to share protected health information with others that are not listed above as necessary to coordinate and facilitate your care.

_____ _____
Signature of patient or personal representative *Date*

Printed name and relationship of personal representative, if applicable:

_____