PROVIDENCE
Physician Group

Family and Friends Authorization

I understand that my healthcare information at Providence Physician Group is protected and I have received a copy of their Notice of Privacy Practices.

The name(s) listed below are family members or friends to whom I wish to grant access to my healthcare information. I will rely on the professional judgement of my provider and his/her designee to share such information as they deem necessary.

I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information form.

I understand that some information is considered “sensitive.” I understand that I must check the specific boxes in order for my provider or his/her designee to release any “sensitive” information.

- ☐ Mental Health/Psychiatric Disorders (including depression)
- ☐ Chemical Dependency (drug and/or alcohol abuse/treatment)
- ☐ HIV/AIDS Virus
- ☐ Sexually Transmitted Diseases

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time.

NAME RELATIONSHIP

1. ______________________________

2. ______________________________

3. ______________________________

Emergency Contact Information

Name: ______________________ Relationship: ______________

Phone Number(s) ______________________ ☐ Home ☐ Work ☐ Mobile

Phone Number(s) ______________________ ☐ Home ☐ Work ☐ Mobile

Patient Name: ______________________ DOB: ______________

Patient Signature: ______________________ Date: ______________

Witness Signature: ______________________ Date: ______________

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