



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 _____