Santa Rosa COMMUNITY HEALTH

srhealth.org

Permission to Share My Personal Health Information

You have the right to control who can see private information about your health (Protected Health Information). Use this form to give permission for a trusted friend or family member to get private information about your medical and dental health care. **You can change these permissions at any time by letting us know in writing.**

_____ **NO,** do not share my Protected Health Information with anyone.

_____ **YES**, I give permission for the person/people listed below to access my private health information which consists of the following:

- Cancel appointments for me
- Talk with my doctor, dentist, or health staff on my behalf
- Drop off or pick up my paperwork, labs, and prescriptions

Expiration: This authorization will automatically expire one year from today, unless I request an earlier expiration.

Name: _____

Relationship to patient: _____ Phone: _____

Name: _____

Relationship to patient: _____ Phone: _____

_____ _____

Patient Name *Date of Birth*

_____ _____

Signature of Patient or Legal Guardian *Date*

_____ _____

Description of Legal Authority to act on Behalf of Patient *Date*
(If applicable)

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