

Permission to Share My Personal Health Information

Patient Name: _____ Birth Date: _____ MRN: _____

You have the right to decide who can see private information about your health (Protected Health Information). Use this form to give permission to a trusted friend or family member to access your medical and dental health information. **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:

Name: _____

Relationship to patient: _____ Phone: _____

This person may (please INITIAL next to each permission you want to give them):

_____ Access my electronic record via MyChart:

Adult to Adult-Full Access (over 18)

Teen to Proxy-Limited Access (11-18)

Self-managed via MyChart account

_____ Access my private health information which consists of the following:

- Make or 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

Name: _____

Relationship to patient: _____ Phone: _____

This person can (please INITIAL next to each permission you want to give them):

_____ Access my electronic record via MyChart:

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Patient Signature

Date

Expiration: Without my expressed revocation, this authorization will expire one year from the date signed.