Community Health Center

Community Health Center, Inc.

PERMISSION TO SHARE HEALTH INFORMATION

Patient Name _____ Date of Birth _____

I give permission to the person(s) listed below to receive information about my healthcare. For example, they may inquire about appointment or referral information, speak with my provider, etc. I understand that my provider will use their professional judgment to make sure that only necessary health information is shared in order to assist in my health care. This permission will be considered ongoing until I state otherwise in writing.

Date of Permission	Name of Individual & Relationship to Patient	Contact Number	Comments/Instructions (i.e., may pick up medication, may disclose test results, etc)

If you should have any questions regarding the sharing of your health care information, please call your provider's office or speak with one of our Patient Service Associates.

Physicians and staff at the Community Health Center, Inc. have my permission to: (Please check all that apply)

☐ Leave message at home with (name of person(s)) _____

☐ Leave voicemail messages at the following numbers:

Home _____ Cell _____ Work _____

_____

Signature of Patient or Legal Guardian **Date**

_____

Printed Name of Patient or Legal Guardian **Relationship**