

*SJ Family Medical Center – Hudson*

**PATIENT CONSENT TO SHARE PHI**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
(please print)

In addition to the allowable disclosures described in the “Notes of Privacy Practices”, I hereby specifically consent to disclosure of my protected health information (PHI) to the person(s) indicated below who are involved in my care (please provide full name/s):

- Any member of my immediate family (husband/wife/children/parents):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Spouse Only:

\_\_\_\_\_

- Other:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I acknowledge that this consent will remain in place until my written notification requesting a change has been received and processed.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date