

SJ Family Medical Center – Sky Meadow

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