

Permission to Share Limited Health Information with Family/Friends



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(801) 364-4030.

Patient Name: _____

D.O.B. _____

Med. Rec. # _____

By signing this paper below, I give permission for the person(s) listed to receive limited information about my care. I understand that my healthcare provider will use their professional judgment to ensure that only information pertinent to assisting in my care is released. Any information that does not pertain to assisting with my health care and any copies of my medical records will require a signed HIPAA compliant authorization. This permission will be considered ongoing until I state in writing otherwise.

Full name of the individual information may be released to	Relationship to patient	Information this person may have access to	Patient's initials
		Check all that apply: <input type="checkbox"/> appointment scheduling <input type="checkbox"/> test results <input type="checkbox"/> pick up meds/prescriptions <input type="checkbox"/> pick up letters/correspondence <input type="checkbox"/> ALL medical information	
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DO NOT release my health information to anyone

The Physician/Staff has my permission to leave a message on my answering machine regarding my care (check all that apply):

Cell phone _____

Home phone _____

Work phone _____

DO NOT leave any messages on my answering machine

Signature of Patient or Legal Guardian

Date

Printed Name of Patient or Legal Guardian

Relationship (if not self)