PERMISSION TO SHARE PHI (personal health information)

I, _____(the patient) hereby grant permission to Rocky Mountain Family Medicine to share my Protected Health Information with the following people or facilities.

1) _____ Relationship: _____

2) _____ Relationship: _____

3) _____ Relationship: _____

4) _____ Relationship: _____

5) _____ Relationship: _____

This includes permission to discuss my treatment plans, medications, lab and radiology results, as well as my diagnoses.

Patient's Signature: _____ Date: _____

Parent/Guardian Signature:_____ Date: _____

Witnessed By: _____
printed name

Witnessed By: _____ Date: _____
signature