PERMISSION TO COMMUNICATE WITH FAMILY MEMBERS AND/OR OTHERS *

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), health care providers are prohibited from releasing or discussing any personal health information to anyone without appropriate permission. Therefore, we need your written authorization if you would like us to communicate with family members or others involved in your care (or your child's care, if applicable). Please let us know with whom we may communicate regarding any aspects of your health care (or that of your child, if applicable).

I, ______________________________ authorize ProHealth Physicians /____________________________
to release or discuss

☐my health information (DOB __/__/____)

☐my minor child/children's health information:

Child's name _____________________ DOB __/__/____
Child's name _____________________ DOB __/__/____
Child's name _____________________ DOB __/__/____
Child's name _____________________ DOB __/__/____

To:
Name: ____ Phone Number:_____________________
Relationship: (check one)(and the person must be at least 18 years old)

☐ Spouse / Partner ☐Mother/Father ☐ Grandparent ☐ Step-parent
☐ Aunt/Uncle ☐ Cousin ☐ Sibling ☐ Foster Parent
☐ Niece/Nephew ☐ Social or DCF Worker ☐ In-law ☐ Friend
☐ Nanny, babysitter or au pair ☐ Son/Daughter
☐ Other: ____________________________________ ☐ Health care agent

This person also has my permission to give consent to treatment: ☐ Yes ☐ No ______
Initial

Additional or Alternative, if desired:

To:
Name: ____ Phone Number: ____________________
Relationship: (check one)(and the person must be at least 18 years old)

☐ Spouse / Partner ☐Mother/Father ☐ Grandparent ☐ Step-parent
☐ Aunt/Uncle ☐ Cousin ☐ Sibling ☐ Foster Parent
☐ Niece/Nephew ☐ Social or DCF Worker ☐ In-law ☐ Friend
☐ Nanny, babysitter or au pair ☐ Son/Daughter
☐ Other: ____________________________________ ☐ Health care agent

This person also has my permission to give consent to treatment: ☐ Yes ☐ No ______
Initial

____ ___________________________
INDIVIDUAL'S SIGNATURE DATE

* This is not a substitute for ProHealth's Standard HIPAA form called

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Revised May 2007