

## 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).

	ealth Physicians /
to release or discuss	
□my health information (DOB//)	
□my minor child/children's health information	on:
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)
$\square$ Spouse / Partner $\square$ Mother/Father	$\Box$ Grandparent $\Box$ Step-parent
<ul> <li>□ Spouse / Partner</li> <li>□ Aunt/Uncle</li> <li>□ Niece/Nephew</li> <li>□ Mother/Father</li> <li>□ Cousin</li> <li>□ Social or DCF Worker</li> </ul>	☐ Grandparent ☐ Step-parent ☐ 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 conser	4.4.4.4.4.D.N.
ims person also has my permission to give conser	nt to treatment: U Yes U No
	Initial
Additional or Altern	Initial
Additional or Altern To:	Initial active, if desired:
Additional or Altern To: Name:	Initial ative, if desired: Phone Number:
Additional or Altern To: Name: Relationship: (check one)(and the person must be at	Initial active, if desired:  Phone Number:  least 18 years old)
Additional or Altern To: Name: Relationship: (check one)(and the person must be at	Phone Number:  least 18 years old)  Grandparent  Step-parent
Additional or Altern To: Name: Relationship: (check one)(and the person must be at Spouse / Partner Mother/Father Cousin	Initial Phone Number:  Phone Number:  least 18 years old)  Grandparent Sibling Foster Parent
Additional or Altern To: Name: Relationship: (check one)(and the person must be at Spouse / Partner Mother/Father Aunt/Uncle Cousin Niece/Nephew Social or DCF Worker	Phone Number:  Phone Number:  least 18 years old)  Grandparent Sibling Foster Parent In-law Friend
Additional or Altern To: Name: Relationship: (check one)(and the person must be at  Spouse / Partner	Phone Number:  Phone Number:  least 18 years old)  Grandparent Sibling Foster Parent In-law Son/Daughter
Additional or Altern To: Name: Relationship: (check one)(and the person must be at Spouse / Partner Mother/Father Aunt/Uncle Cousin Niece/Nephew Social or DCF Worker	Phone Number:  Phone Number:  least 18 years old)  Grandparent Sibling Foster Parent In-law Son/Daughter
Additional or Altern  To: Name: Relationship: (check one)(and the person must be at  Spouse / Partner	Phone Number:  Phone Number:  least 18 years old)  Grandparent Sibling Foster Parent In-law Son/Daughter Health care agent
Additional or Altern To: Name: Relationship: (check one)(and the person must be at  Spouse / Partner	Phone Number:  Phone Number:  least 18 years old)  Grandparent Step-parent  Sibling Foster Parent  In-law Friend  Son/Daughter  Health care agent  To treatment: Yes No
Additional or Altern  To: Name: Relationship: (check one)(and the person must be at  Spouse / Partner	Phone Number:  Phone Number:  least 18 years old)  Grandparent Sibling Foster Parent In-law Son/Daughter Health care agent
Additional or Altern  To: Name: Relationship: (check one)(and the person must be at  Spouse / Partner	Phone Number:  Phone Number:  least 18 years old)  Grandparent Step-parent  Sibling Foster Parent  In-law Friend  Son/Daughter  Health care agent  To treatment: Yes No
Additional or Altern  To: Name: Relationship: (check one)(and the person must be at  Spouse / Partner	Phone Number:  Phone Number:  least 18 years old)  Grandparent Step-parent  Sibling Foster Parent  In-law Friend  Son/Daughter  Health care agent  To treatment: Yes No

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

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