CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Today's Date:_____

D.O.B:_____

I, _____ am granting permission to Compassion Care Clinic to allow the follwoing people including themselves to have access to my protected health and medical information (PHI). I understand taht I may revoke this consent at any time by compelting a new consent form. ***Please fill in the names of the persons to whom you allowing us to release the mentioned infortion to (PHI).***

SPOUSE:_____

PARENT:_____

CHILD:_____

GRANDPARENT:_____

GRANDCHILD: _____

AUNT/UNCLE: _____

LEGAL GUARDIAN: _____

I DO NOT GRANT DISCLOSURE OF MY PROTECTED HEALTH INFORMATION TO ANYONE BUT MYSELF

May we leave you or your designated individual/s message regarding appointment? YES/NO

May we leave you or your designated individual/s message regarding test/lab results? YES/NO

May we leave you or your designated individual/s message regarding billing related questions? YES/NO

Patient/Legal Gaurdian Signature: _____