TEST, PATIENT (id #1, dob: 05/01/2018)

OBGYN, PEDIATRICS & INTERNAL MEDICINE

CONSENT FOR RELEASE OF INFORMATION TO FAMILY MEMBER/CAREGIVER

I, **PATIENT TEST** ______________________, consent for Physicians & Surgeons Clinic to
(Print Patient Name)
disclose any and all of my protected health information(PHI) concerning my medical treatment or care (including but not limited to) laboratory and other test results, immunizations, x-rays, appointments, referrals to other physicians, medications, diagnoses, and prognoses to the following caregivers:

		Check if emergency contact
1. Name: ______________________	Relationship: ______________________	☐
2. Name: ______________________	Relationship: ______________________	☐
3. Name: ______________________	Relationship: ______________________	☐
4. Name: ______________________	Relationship: ______________________	☐

I understand that it is my responsibility to notify Physicians & Surgeons Clinic of any changes to the above information. If changes do occur, I understand that I must file in writing another *Consent for Release of Information to Family Member/ Caregiver.*

I understand that I may revoke this consent at any time by submitting a written revocation except to the extent that action has already been taken by Physicians & Surgeons Clinic reliance on my consent.

This *Consent for Release of Information to Family Member/Caregiver* will remain in full force and effect unless changed or revoked by me in writing.

______________________	**05/01/2018**	______________________
Signature of Patient/Patient Representative	Patient DOB	Date

BELOW TO BE COMPLETED ONLY IF SIGNED BY SOMEONE OTHER THAN THE PATIENT

Printed Name of Patient's Representative: ______________________

Description of Rep's Authority to act for Patient: ______________________

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Relationship to the Patient: ______________________

Signature of Witness: ______________________