

Patient Name: _____ Birth Date: _____
 Please Print

Please read the following and complete the information requested

You have the right to identify individuals other than your health care providers who are involved in your care (family, friends, or others). We may verbally share your medical information to an individual you have identified as involved in your medical care. We may also give information to someone who helps pay for your care. EvergreenHealth will only share your health information with the individuals you designate, except as required or permitted by law. You may add or change this list at any time.

Information related to Mental Health, Chemical Dependency, or HIV testing and/or therapy will only be shared with you unless specifically authorized below. (Sensitive Information)

I DO NOT authorize EvergreenHealth to verbally share information with anyone.

I authorize EvergreenHealth to verbally share medical information/billing information with the individuals listed below:

Name	Relationship to Patient	Information to Share
		<input type="checkbox"/> All, including sensitive information <input type="checkbox"/> All, not including sensitive information <input type="checkbox"/> Specific: _____
		<input type="checkbox"/> All, including sensitive information <input type="checkbox"/> All, not including sensitive information <input type="checkbox"/> Specific: _____
		<input type="checkbox"/> All, including sensitive information <input type="checkbox"/> All, not including sensitive information <input type="checkbox"/> Specific: _____

I agree I may be contacted for appointments or follow-up information about my care at the following numbers:

Primary contact # _____ Ok to leave detailed message? Yes No

Secondary contact # _____ OK to leave detailed message? Yes No

These designations will remain in effect indefinitely or until otherwise revoked by me in writing.

Signature: _____ Date: _____
 (if signed by a personal representative of the patient, please complete the following:)

Personal Representative's Name: _____

Relationship to Patient: Parent Legal Guardian* Holder of a Medical Power of Attorney*

* Please attach Legal Documentation if you are the Legal Guardian or Holder of Power of Attorney