Three Rivers Family Medicine, PSC

Consent To Inform – Your Right to Privacy

****PLEASE PRINT****

PATIENT'S Name:_____

We respect your right to privacy regarding medical information. With your written consent below, we may share information with your spouse.

Signature: _____Date: _____

Spouse Full Name:_____

We understand you may have concerned family members. Please list the names of adults, children, other family members and/or contact persons with whom we may share information, and their relationship to the patient:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

You may use or disclose the following health care information (check all that apply):

□ **All health care information in my medical record**

□ **Other —specify date(s) or conditions: _____**

You may use or disclose health care information regarding testing, diagnosis, & treatment for (check all that apply):

□ **HIV/AIDS** □ **Sexually Transmitted Diseases** □ **Mental Health or Illness**

□ **Drug and/or Alcohol Abuse** □ **Reproductive Care (minors only)**

Minors – a minor patient's signature is required in order to disclose information related to reproductive care, sexually transmitted diseases (if age 14 and older), HIV/AIDS (if age 14 & older), drug &/or alcohol abuse (if age 13 & older), & mental health or illness (if age 13 & older).

_____ _____

Signature of patient or patient's authorized representative **Date**

_____

Relationship or status if signed by anyone other than patient

If there are any changes to be made to this authorization, it is the patient's responsibility to inform TRFM.

THIS AUTHORIZATION WILL EXPIRE YEARLY, UNLESS OTHERWISE REVOKED