St John's Medical Center

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CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION TO PERSONAL REPRESENTATIVE, FAMILY OR FRIEND

Patient Name: _____ Birthdate: _____

Patient Address: _____ Telephone: _____

I. Personal Representative(s):

- I acknowledge that the following person(s) are my personal representative(s), and I consent to St. John's Medical Center disclosing my protected health information to them as it would to me.

Name of Representative: _____Phone Number: _____

Mailing Address: _____ Fax Number: _____

City: _____State: _____ Zip Code: _____

Source of Personal Representative's Authority (i.e. Power of Attorney, Parent of Minor, Guardian):

_____

II. Family Members, Friends:

- I acknowledge that the following person(s) are my family members and/or close personal friends and are directly involved in my health care, and I consent to St. John's Medical Center disclosing my protected health information to any or all of them to the extent relevant to their involvement in my care or payment related to my care, and to notify such persons of my location, general condition or death.
- The persons listed below may not be my only family members and/or close personal friends, and I reserve the right to consent to St. John's Medical Center disclosing my protected health information for the same purpose(s) to other persons as well.

Name of Representative: _____Phone Number: _____

Mailing Address: _____ Fax Number: _____

City: _____State: _____ Zip Code: _____

Relationship to Patient: _____

Unless revoked, this Consent will be in force and effect until the following (check one)

☐ Date: _____ -OR- ☐ Event: _____

A photocopy or fax of this Authorization shall be valid as the original

Patient Signature: _____ Date: _____

Legally Authorized Representative: _____ Date: _____

Relationship to Patient: _____

Witnessed: _____ Date: _____

Method of Delivery: MAIL FAX PICK UP Date: _____