GreenField Health

WESTSIDE | 9450 SW Barnes Road, Suite 100 • EASTSIDE | 700 NE Multnomah, Suite 400 • 503-292-9560 • FAX: 503-292-9510

OTHERS INVOLVED IN HEALTHCARE

As stated in our Notice of Privacy Practices, we may disclose your protected health information to a member of your family, a relative, a close friend or any other person that you choose.

Patient Last Name (PLEASE PRINT)	First Name	M.I.	D.O.B.	SSN #

I give GreenField Health permission to discuss my protected health information with the following person (s):

Name	Phone Number	Relationship
Name	Phone Number	Relationship
Name	Phone Number	Relationship
Name	Phone Number	Relationship
Name	Phone Number	Relationship

I understand that my records are protected under the federal and state confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that GreenField Health cannot guarantee that the recipient of this information will not re-disclose my health information to another party. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it.

_____ _____

Signature of Patient or Patient's Legal Representative Date

_____ _____

Print Name Relationship to Patient