

Hudson's Bay Medical Group

PHI Release for Family Members and Caregivers

Today's Date _____

Patient Name(Print)

Date of Birth

I, _____ give my permission to have my personal
Patient Name
health information (PHI) released to the following family members and or
caregivers.

List family members and or caregivers below:

_____, _____
Name

Relationship

_____, _____
Name

Relationship

_____, _____
Name

Relationship

I understand that by signing this agreement, I am giving my permission for
the above listed people to discuss my personal health information. I also
understand that this release is valid until revoked in writing.

Patient Signature

Date

Last Update _____