PHI RELEASE FOR FAMILY MEMBER(S) AND CAREGIVERS

_____ _____

Patients Name (PRINT) Today's Date

_____

Date of Birth

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

_____, _____, _____

NAME RELATIONSHIP PHONE NUMBER

_____, _____, _____

NAME RELATIONSHIP PHONE NUMBER

_____, _____, _____

NAME RELATIONSHIP PHONE NUMBER

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

_____, _____

PATIENT SIGNATURE DATE

TREATMENT OF MINORS

_____

Patients Name (PRINT)

_____

Date of Birth

I give my permission to have the physicians and medical staff at Hudson's Bay Medical Group to treat my child who is a minor and needs my permission except when the following may apply:

- **EMANCIPATION.**
- **EMANCIPATION OF MARRIAGE TO SPOUSE OVER 18 YEARS OF AGE.**
- **EMERGENCY MEDICAL CARE.**
- **BIRTH CONTROL, PREGNANCY TERMINATION & ANY MEDICAL CONDITION RELATED TO PREGNANCY.**
- **HIV AND/OR ANY SEXUALLY TRANSMITTED DISEASE (14 & OLDER).**
- **OUTPATIENT SUBSTANCE AND/OR MENTAL HEALTH (13 & OLDER).**

_____, _____

PATIENT NAME PARENT OR GUARDIAN NAME

_____, _____

PARENT OR GUARDIAN SIGNATURE DATE