Permission for Disclosure to Family, Friends and/or Caregivers

To be filled out by patient:

I understand that my health information is protected and confidential. I give permission for MCH ProCare physicians and staff to discuss my health related matters with family, friends, caregivers, and other designated persons listed below.

Patient Name: _____

DOB: _____

Patient Signature: _____ Date: _____

Relevant health information may be shared with the following people:

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship