PERMISSION TO SHARE PROTECTED HEALTH INFORMATION

Idaho Hand Center maintains strict confidentiality on all our patients. We respect an individual patient's right to decide who may receive information about their treatment, results, appointment times, and/or anything pertinent to your health as it relates to information held on file or with the physicians/staff here at Idaho Hand Center.

By indicating below who you are authorizing to receive protected health information about you, we will respect your wishes and only release information to them. We recognize that situations change and you are always permitted to revise this document, at any time.

I, ____, hereby allow the doctors and/or staff of Idaho Hand
Patient's Printed Name
Center to release appropriate protected health information on myself to the following people:

Name:____ Relationship:_______________________

Name:____ Relationship:_______________________

Name:____ Relationship:_______________________

Name:____ Relationship:_______________________

Name:____ Relationship:_______________________

Name:____ Relationship:_______________________

Patient's Signature:____ Date:________________
Patient or Responsible Party