



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 #
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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