NEW BEGINNINGS
Mental Health and Wellness

Permission to Share My Personal Health Information (HIPAA)

Patient Name: _____ Date of Birth: _____

You have the right to control who can see private information about your health (Protected Health Information). Use this form to give permission for a trusted friend or family member to get private information about your health care. **You can change these permissions at any time by letting us know in writing.**

_____ **NO,** do not share my Protected Health Information with anyone.

_____ **YES**, I give permission for the person/people listed below to access my private health information:

Name: _____

Phone Number: _____

This person can (INITIAL all the permissions you want to give):

_____ Make or cancel appointments for me
_____Talk with my doctor or health staff on my behalf
_____ Handle my paperwork, labs, and prescriptions
_____ See my complete medical records

Name: _____

Phone Number: _____

This person can (INITIAL all the permissions you want to give):

_____ Make or cancel appointments for me
_____Talk with my doctor or health staff on my behalf
_____ Handle my paperwork, labs, and prescriptions
_____ See my complete medical records

_____ _____
Patient Signature Date