GOOD SHEPHERD MEDICAL GROUP
PERMISSION TO SHARE PATIENT HEALTH INFORMATION

I,_____/_____
(Patient name, please print) (Date of Birth)

Authorize those named below to:

1._____

	Discuss any or all medical or financial information regarding my care
	Request or receive any or all medical or financial information regarding my care
	Receive information regarding HIV, STD, or other sexually related information
	Bring the above named patient to his/her provider appointments
	Other, please specify:

2._____

	Discuss any or all medical or financial information regarding my care
	Request or receive any or all medical or financial information regarding my care
	Receive information regarding HIV, STD, or other sexually related information
	Bring the above named patient to his/her provider appointments
	Other, please specify:

3._____

	Discuss any or all medical or financial information regarding my care
	Request or receive any or all medical or financial information regarding my care
	Receive information regarding HIV, STD, or other sexually related information
	Bring the above named patient to his/her provider appointments
	Other, please specify:

DECLINE: _____Please do not communicate any information about my care at Good Shepherd Medical Group with my family members or friends. **I understand this also means that no one else will be able to make payments on my account on my behalf.**

This information is updated annually, in order to protect your privacy; it is your responsibility to inform our office of any changes that occur throughout the year.

SIGNATURE:_____DATE:_____
(Patient or Parent/Guardian)

GSMG OFFICE USE ONLY

WITNESSED:_____DATE:_____