WOODCREEK HEALTHCARE

Consent to Share/Exchange Information & Contact List

Patient's Name (First MI Last) _____ Patient's DOB (MM/DD/YYYY) _____

Woodcreek Healthcare would like to have your authorization to disclose certain protected health information to a family member or other individual because they are involved with your/your child's healthcare. **If you would like a copy of your medical record, please fill out an *Authorization to Use or Disclose Protected Health Information* Form.**

I AUTHORIZE WOODCREEK TO DISCUSS (check all that apply)

☐ Appointment History ☐ Medications ☐ Lab Results ☐ Billing/Financial Information

☐ Sexually transmitted disease (STD) records (including HIV/AIDS) testing and treatment ☐ Birth control/family planning

☐ Mental Health diagnoses and treatment ☐ Drug, Alcohol and Substance use history and treatment

☐ Other: _____

WITH THE FOLLOWING PEOPLE

Print Name	Phone	Message OK?	Relationship to patient	Emergency Contact
		☐		☐
		☐		☐
		☐		☐
		☐		☐

- I understand I do not have to sign this authorization in order to receive health care benefits (treatment, payment or enrollment)
- I understand that I am not required to list anyone. I understand that this information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without a properly signed Release of Information Form. It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time.
- I understand that Woodcreek will in no way use this information for marketing purposes. I also understand that once health care information is disclosed, the person that receives it may re-disclose it. Privacy laws may no longer protect it.
- This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that to revoke this consent, I must provide written notice to Woodcreek Healthcare.

Release of Information of a Minor – The minor is ***required*** to sign this consent if the following conditions are met:

Any age: Birth control and prenatal care records OR The minor is legally emancipated or married to either an adult or an emancipated minor
14 years of age or older: Sexually transmitted disease (including HIV) records
13 years of age or older: Mental health records OR Substance abuse records

This authorization will expire one (1) year after the date it is signed. This authorization will be reviewed annually.

Signature _____ Printed Name _____ Relationship to patient _____ Date _____