Communication Consent Agreement

I understand under federal law (HIPAA), the Redding Rancheria Trinity Health Center (RRTHC) may NOT release any medical information to any individual, without my express written permission. Law enforcement and court order are two exceptions to this requirement. I, therefore, GIVE permission to the RRTHC to release medical information on my behalf, to the following person (s): (Please note—any family member/friend—other than your doctor's office—can be listed. If none—please check the "I do not wish…" box and sign below.

Name: _____ Relationship: _____

Address: _____

City _____ State _____ Zip _____

Phone Number: _____ Age: _____ Birth date: _____

Name: _____ Relationship: _____

Address: _____

City _____ State _____ Zip _____

Phone Number: _____ Age: _____ Birth date: _____

Name: _____ Relationship: _____

Address: _____

City _____ State _____ Zip _____

Phone Number: _____ Age: _____ Birth date: _____

☐ You may release my medical information to the above listed persons.

☐ **I do not wish to release any of my medical information at this time to family members and/or friends.**

Pleas print your name here: Patient Signature: _____

_____ Date: _____