



Consent to Allow Family Member or Other Person Involved in Care or Payment to Access Medical Information

Patient name: _____

1. I am either the patient identified above, or I am the personal representative of the patient with legal authority to make health care decisions for the patient.

2. The person(s) listed below are family members or others who are involved in the patient's health care or payment for healthcare. I give permission to Idaho Physical Medicine and Rehabilitation ("IPMR") to disclose the patient's protected health information to such persons.

[List names, relationship and phone numbers of persons]:

NAME	RELATIONSHIP	PHONE NUMBER

3. In addition to the persons listed above, there are or may be other persons who are involved in the patient's health care or payment for health care. This consent is not intended to limit IPMR's authority to disclose protected health information to such other persons to the extent allowed by applicable law, including but not limited to 45 CFR 164.510.

Signature

Date

If signed by a Personal Representative:

Print name of Personal Representative

State authority of Personal Representative or relationship to patient.