



## SHARING OF PRIVATE INFORMATION

Please list any other parties who can have access to patient's health information or that we are allowed to discuss patients' health information with. Examples can be significant other, other family member, mother/father etc.

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Patient Name : \_\_\_\_\_

Patient Signature : \_\_\_\_\_

Date : \_\_\_\_\_