CARRBORO FAMILY MEDICINE CENTER, P.A.

Patient Centered. Community Based.

PATIENT CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

If we are unable to reach you, are there any relatives or friends with whom you authorize our office to discuss you health information?

Yes________________ No_________________

If yes, please list their names, relationship and phone numbers.

1) Name: ____

Relationship: ____

Phone number: ____

2) Name: ____

Relationship: ____

Phone number: ____

This authoriztion is in effect until revoked in writing.

Print patient name: ____

Patient/guarantor signature: ____

Date: ____