THE PURCELL CLINIC PA
CONSENT FOR RELEASE OF
PROTECTED HEALTH INFORMATION TO OTHER PERSONS

I consent to disclosure of the following protected health information about My child/children listed below:

_____ DOB_____

_____ DOB _____

_____ DOB_____

_____ DOB_____

To the following person/persons:

_____ Relationship_____

_____ Relationship_____

_____ Relationship: _____

I understand that the designated persons above will have access to any and all medical information regarding my child/children listed above. They may bring them to the office and make medical decisions if necessary. They may make appointments and give information necessary to bill for or submit claims for care for my child/children to government or private organizations. _____
Initials

My consent will remain in effect as long as I am a patient of The Purcell Clinic unless and until I notify Purcell Clinic in writing of any changes.

_____ _____
Signature of Patient or Representative Date

_____ _____
Print Name Representative

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