PATIENT CONSENT TO SHARE PHI

Patient Name: ______________________________ DOB: ________________
(Please print)

I hereby consent to disclosure of my protected health information (PHI) to the person(s) indicated below. Please provide full name(s):

Any member of my immediate family (husband/wife/children/parents):

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Spouse Only:

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Other:

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I acknowledge that this consent will remain in place until my written notification requesting a change has been received and processed.

______________________________ ________________
Patient Signature Date

1672 South County Trail, Suite 101 & 301
East Greenwich, RI 02818