

# Sherwood Family Medicine

## Others Involved in Healthcare

As stated in our Notice of Privacy Practices, we may disclose your protected health information that is directly related to that person's involvement in your health care to a member of your family, a relative, a close friend or any other person that you choose.

We request that you designate the individuals with whom we may discuss your protected health information.

The permission granted below may be rescinded and/or modified at any time. Such a change must be made in writing to :

**Sherwood Family Medicine**  
**20015 SW Pacific Hwy., Ste. 300**  
**Sherwood, OR 97140**

I, \_\_\_\_\_, give Sherwood Family Medicine permission to discuss my protected health information with the following person(s):

NAME	Phone Number	Relation
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

