Consent to Allow Family Member(s) or Other Person(s)
Involvement in Health Care, Payments and Access to Protected Information for:

Patient's Name: _____

Patient's Date of Birth: _____

1. I am either the Patient identified above or I am the personal representative of the Patient with legal authority to make health care decisions for the Patient.

2. I consent for the person(s) listed below, who are family members or others, to be involved in the Patient's health care or payment for health care. I give permission to **Pocatello Children's Clinic** to disclose any of the Patient's protected health information to such persons.
   (List names and phone numbers of persons):

   _____ _____

   _____ _____

   _____ _____

   _____ _____

3. In addition to the persons listed above, there are or may be other persons who are involved in the Patient's health care or payment for health care. This consent is not intended to limit Pocatello Children's Clinic's authority to disclose protected health information to such other persons or to other entities to the extent allowed by applicable law, including but not limited to 45 CFR §§ 164.506, 164.510 and 164.512 and Pocatello Children's Clinic does not agree to such restrictions.

This consent will expire on the following date or event: _____
If no specific date or event is stated, this consent will expire one (1) year from the date signed. I understand that I have the right to revoke this consent at any time except to the extent that the Pocatello Children's Clinic has taken action in reliance to this consent.

Name (please print): _____ Phone: _____

Signature: _____ Date: _____

If a personal representative, describe relationship to patient or authority: _____

_____

(09/2017)