## *SHAWNEE HEALTH SERVICE*

**Patient Request for Shawnee Health Service to Release Confidential Information**

Unless you provide us with permission on this form, we cannot give your family members or friends information about your visits at our health center. Please let us know if you would like others included in your health care. One word of caution – once we give a person any information, we have no control over whether the person will keep that information private. Thank you!

☐ **Check here if you do not want anyone to receive information**

| Who can we share Information with? (List their name and address) and then check what can be shared | All information | Appointments | Lab or Test Results | Medical information | Dental Information | Patient Portal (limited access) | Patient Portal (full access) | Other - please list |
|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| 4 | | | | | | | | |

**We will contact you at your address and telephone number on your registration form. If you do not want us to contact you at that address or telephone number, please list where we can contact you:**

_____

**Do you have any other requests? Please list those here:**

_____

Patient Name (please print): _____ Date of Birth: _____

Signature of Patient or Legal Guardian: _____ Date: _____

Relationship to Patient (if not patient): _____

Printed Name: _____