MOUNTAINSTAR
South Jordan
Family Medicine
affiliated with St. Mark's Hospital

PERMISSION TO SHARE LIMITED HEALTH INFORMATION WITH FAMILY/FRIENDS

Patient Name: _____ Date of Birth: _____

By signing this paper below, I give permission to the person(s) listed in the table documented to receive limited information about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friend in order to assist with my continuing care. Any information that does not pertain to assisting with my health care and any copies of medical records will require a signed HIPA compliant authorization. This permission will be considered ongoing until I state in writing otherwise.

Date of Permission	**Name of Individual & Relationship to Patient**	**Comments/Instructions** (i.e., may disclose appointment reminders and test results, may pick up meds, etc)	**Patient or Guardian Initials**

THE PHYSICIAN/STAFF HAS MY PERMISSION TO: (Please check all boxes that apply)

☐ Leave a message on my home phone Home Phone Number: _____

☐ Leave a message on my cell phone Cell Phone Number: _____

☐ Leave a message on my work phone Work Phone Number: _____

☐ Do not leave a message on any phone

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Printed Name of Patient or Legal Guardian Relationship (if not self)