Patient Label

Communication Consent Agreement

I understand under federal law (HIPAA), the Redding Rancheria Tribal Health Center (RRTHC) may NOT release any medical information to any individual, without my express written permission. Law enforcement and court order are two exceptions to this requirement. I, therefore, GIVE permission to the RRTHC to release medical information on my behalf, to the following person (s): (Please note—any family member/friend—other than your doctor's office—can be listed. If none—please check the "I do not wish…" box and sign below.

Name:_____Relationship: _____

Address:_____

City_____State_____Zip_____

Phone Number:_____Age:_____Birth date: _____

Name:_____Relationship: _____

Address:_____

City_____State_____Zip_____

Phone Number:_____Age:_____Birth date: _____

Name:_____Relationship: _____

Address:_____

City_____State_____Zip_____

Phone Number:_____Age:_____Birth date: _____

☐ You may release my medical information to the above listed persons.

☐ **I do not wish to release any of my medical information at this time to family members and/or friends.**

Print Patient Name Here:_____

Patient Signature:_____ Date:_____