

# *Merrimack Valley Pediatrics*

## **PATIENT CONSENT TO SHARE PHI**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
(please print)

In addition to the allowable disclosures described in the "Notice of Privacy Practices," I hereby specifically consent to disclosure of my protected health information (PHI) to the person(s) indicated below who are involved in my care (please provide full name/s):

- Any member of my immediate family (husband/wife/children/parents):

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- Spouse Only:

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- Other:

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I acknowledge that this consent will remain in place until my written notification requesting a change has been received and processed.

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

\_\_\_\_\_  
Date

505 West Hollis Street · Suite 101 · Nashua · New Hampshire 03062 · (603) 880-1440