# *Dahl Memorial Clinic*

*Municipality of Skagway*

## Consent to Disclose Personal Health Information

We respect your right to privacy regarding medical information. We will NOT share your Personal Health Information (PHI) with any family member, friend, significant other, or spouse without your written consent. If you would like to authorize us to share your PHI with someone, please list them below. This consent form is NOT applicable to Behavioral Health records on file.

I **consent** to allowing the providers and staff of Dahl Memorial Clinic to discuss my PHI, excluding any Behavioral Health records, with my family members, significant other, or my personal representative listed below:

**NAME:**_____**Relationship:**_____**Phone:**_____

**NAME:**_____**Relationship:**_____**Phone:**_____

**OR**

_____ I **restrict** the providers and staff of Dahl Memorial Clinic from discussing my PHI with anyone other than myself.

I understand that I may revoke this consent in writing, but that revocation will not be effected to the extent that Dahl Memorial Clinic has already taken action in reliance on my earlier effective consent.

_____
**Signature of Patient or Legal Representative**

_____
**Printed Name**

_____
**Witness**

_____
**Date**