Brown Clinic P.L.L.P
Personal Care from the People You Know and Trust.

Request for Disclosure of Protected Health Information (PHI) to designated representative or family members

Patient Name: _____ Birthdate: _____

Patient Address: _____

_____

_____

As a patient of the Brown Clinic, PLLP, I request that my family or appointed representative is involved in my medical decision making process. This would allow the Medical Providers of the Brown Clinic, PLLP to discuss my personal health information with my designated family member or representative.

I give authorization to discuss/disclose my protected health information (PHI) with the following family members or appointed representatives:

	Name	Address	Phone Number
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____

_____ _____

Signature Date