



ST. JOSEPH'S CARE GROUP

CONSENT TO DISCLOSE/COLLECT PERSONAL HEALTH INFORMATION

Place Patient Label with Barcode Here

I _____ hereby authorize **ST. JOSEPH'S CARE GROUP** to

DISCLOSE Verbally or Copies of record(s)

COLLECT Verbally or Copies of record(s)

Description of information being requested or disclosed.

Name and address of Person/Agency disclosing or requesting to access.

Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

from the records of _____ (Name of Client) _____ (Birth date)

of _____ (Mailing Address of the Client)

I understand that this personal health information is to be used **only** by the recipient for the purposes of:

I hereby waive any and all claims against **ST. JOSEPH'S CARE GROUP** in connection with the disclosure of this personal health information.

I understand that I may withdraw this consent at any time by contacting a member of my treatment team.

Witness: _____ Signed by: _____ (Client or Substitute Decision-Maker)

Date: _____ (Relationship to the Client)

