Foothills Family Care

Rebecca L. Goldman, M.D.
Rebecca F. Moran, M.D.

Patient Name:_____

Date of Birth:_____

Protected Health Information consent

I have received a copy of the HIPPA Privacy Rules from *Foothills Family Care*, and I authorize the following list of people who may receive my Protected Health Information. I understand that I may revoke this authorization at anytime by giving written notification to this office.

These people may receive my Protected Health Information:

Name: _____ Date of Birth: _____

Relationship to Patient: **Spouse** **Child** **Parent** **Significant Other**

Name: _____ Date of Birth: _____

Relationship to Patient: **Spouse** **Child** **Parent** **Significant Other**

Name: _____ Date of Birth: _____

Relationship to Patient: **Spouse** **Child** **Parent** **Significant Other**

Name: _____ Date of Birth: _____

Relationship to Patient: **Spouse** **Child** **Parent** **Significant Other**

Signature:_____ Date:_____