Peter C. Brasch, M.D. LLC
1 Thurber Blvd. Smithfield, RI 02917 Telephone: (401) 349-5360 Fax: (401) 349-5270

HIPAA contact / sharing information consent

Patient name _____ Date of Birth _____

I hereby give my permission for Peter C. Brasch, M.D. to share / disclose my protected health information to the following person(s):

*** Due to HIPAA regulations, we may only discuss your health information with people you have listed below. This includes parents (of children 18 and over), family members, spouses, etc.

Name	Phone number:	Relationship to patient:

This form will remain valid unless you alert us in writing to revoke this consent or that there have been changes to names listed above. If changes are necessary, a new form may be required.

Patient's Signature _____ Date _____