Bluewater Respite Inc.

PHIPPA PRIVACY RIGHTS

Consent to Disclose Personal Information Form

Name (Last, first, middle initial) Full Name of Custodial parent, legal Guardian or Client 16 years or over

Date

Street address, City, ST, ZIP Code

Primary phone number | Other phone number

Email address

Type of Request

c Documentation c Amendment c Restriction
c Confidential communication

Please describe nature of action requested (type of information requested; nature of amendment, restriction, documentation, or confidential communication, etc.) **in detail**.

Please list staff members or Facility that will be involved regarding this matter:

Name

Date

Name

Date

Signature

Date

Client's Name

Client's Date of Birth(yyyy-mm-day)

I understand the purpose for disclosing this health information. I understand that I can refuse to sign this consent form or later withdraw my consent. Until consent is withdrawn, further disclosure is permitted to the identified person or facility above for the same purpose. This consent will remain active until Client contract is terminated or until consent is withdrawn.

Witness

Specify Relationship to Client

Signature of Custodial Parent, Legal Guardian or Client Age 16 or older

Date

Attach additional documentation, if applicable.