Merrimack Valley Counseling Association

39 Simon St., #2A
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Patient Consent to Share Protected Health Information

Patient Name: _____ DOB: _____
(please print)

In addition to the allowable disclosures described in the "Notes of Privacy Practices," I hereby specifically consent to disclosure of my protected health information (PHI) to the person(s) indicated below who are involved in my care (please provide full name/s):

- Any member of my immediate family (husband/wife/significant other/children/parents)
  _____
  _____
  _____

- Spouse/significant other only:
  _____

  Other:
- _____
- _____
- _____

I acknowledge that this consent will remain in place for one year from the date of signing, or until my written notification requesting a change has been received and processed.

_____ Date: _____
Patient Signature