MINNESOTA OCCUPATIONAL HEALTH
REQUEST FOR FAMILY MEMBER TO HAVE ACCESS TO PROTECTED HEALTH INFORMATION (PHI)

Patient Name:____

Account Number:____

I, ____, authorize Minnesota Occupational Health to disclose my Protected Health Information (PHI) including billing information to the following family members:

	NAME	RELATIONSHIP
1.	___________________________________	____________________________
2.	___________________________________	____________________________
3.	___________________________________	____________________________

I understand I may revoke this authorization by sending a written request for revocation to Shenea Wisniewski, Minnesota Occupational Health's HIPAA Privacy Officer. I understand when Minnesota Occupational Health discloses this information pursuant to this authorization; the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information.

I understand and agree to the terms of this authorization:

____ ____________________________

Patient Signature Date