Health Information Sharing

If you want Primary Medicine, LLC to share information about you with another person or organization, please make sure that you fill out all the sections below. This will tell us what information you want us to share and who to share it with.

I, ____________________________________ give my permission for Primary Medicine, LLC to share my health information with the following individuals or organizations.

I authorize the following permissions:

- ☐ The following people **MAY** have complete access of all my health information including information about sexually transmitted diseases and infections. This includes lab results, medications, treatments, history, office visits:

  ____

- ☐ The following people may have complete access of all my health information **EXCLUDING** information about sexually transmitted diseases and infections:

  ____

- ☐ The following people may have access to limited information about my health care which I have specified below:

  ____

  ____

I understand that Primary Medicine, LLC may share my personal health information with the authorized individuals or entities during the duration of my care as an active patient. If I wish to revoke permission, I must do so in writing to the Primary Medicine, LLC location where I am registered.

____ _____________

Signature Date