

**Mukilteo Smiles
Stacey C. Sype
4901 81st Place SW
Mukilteo, WA 98275**

CONSENT TO SHARE INFORMATION WITH FAMILY/FRIENDS

Patient: _____

I understand that my information at Mukilteo Smiles is protected and I have received a copy of its Notice of Privacy Practices.

The name(s) listed below are family members or friends to whom I grant permission for my healthcare provider and representatives of Mukilteo Smiles to discuss my care, which may be verbal or written, using their best judgment, and grant them permission to disclose health information that is relevant to my care or relevant to payment.

	NAME	RELATIONSHIP
1.	_____	_____
2.	_____	_____
3.	_____	_____

Patient/Guardian Signature

Date

Print Guardian's Name

It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time.

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that to revoke this consent, I must provide written notice to Mukilteo Smiles.