GREENWICH BAY MEDICINE &
BLACKSTONE VALLEY MEDICINE
DIVISIONS OF MDRI

Confidential Communications

Patient Name:_____Date of Birth:_____/___/_____

Use this section to AUTHORIZE others who may contact MDRI/Greenwich Bay Medicine on your behalf to obtain Protected Health Information (PHI) and to communicate with our practice regarding the patient above. (spouse/children/parent/friends etc.)

Authorized User #1: _____ Date of Birth: _____/_____/_____

Relationship to You: _____ Phone# ( ) _____-_____

Authorized User #2: _____ Date of Birth: _____/_____/_____

Relationship to You: _____ Phone# ( ) _____-_____

Authorized User #3: _____ Date of Birth: _____/_____/_____

Relationship to You: _____ Phone# ( ) _____-_____

Use this section to request that MDRI/Greenwich Bay Medicine DOES NOT disclose my PHI with the following individuals

Unauthorized User #1: _____ Date of Birth: _____/_____/_____

Relationship to You: _____ Phone# ( ) _____-_____

Unauthorized User #2: _____ Date of Birth: _____/_____/_____

Relationship to You: _____ Phone# ( ) _____-_____

Patient Signature: _____ Date: _____/_____/_____