
Drs. Hyde, Bailey, Miller and Cremer

Health Information Access

The following names are of people, including myself, that I would like to be involved in or have access to my child's protected health information. I give permission for Drs. Hyde, Bailey, Miller and Cremer to share my child's protected health information with:

| Name | Relationship | SS # /or Drivers License |
|------|--------------|--------------------------|
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| Name | Relationship | SS# /or Drivers License |
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| Name | Relationship | SS# /or Drivers License |
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| Name | Relationship | SS# or/ Drivers License |
|------|--------------|-------------------------|
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| Signature | Relationship | Date |
|-----------|--------------|------|
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If you wish to add or terminate information access to or from the above list, you must submit your request in writing to the office your child(ren) attend.