PERMISSION TO DISCUSS PHI

Patient Name: _____ **Date of Birth:** _____

Account Number: _____

I hereby give my permission to the person(s) listed below to receive information about the care of the above named patient:

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____

Signature of Patient, Parent or Guardian

_____

Date

In order to obtain information by telephone, the party calling the practice must share the patient identifier with the staff.

Patient Identifier: _____