PERMISSION TO DISCUSS PHI

Patient Name: ______________________________ Date of Birth ___________________

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

NAME	RELATIONSHIP

I HAVE READ THE CONSENT FORM AND NOTICE OF INFORMATION PRACTICES AND I AGREE WITH THE TERMS IN THIS NOTICE.

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

Patient Identifier: ________________________________
(Patient Date of Birth)

____ ____________________

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE