Permission to Disclose Private Health Information

Patient's Name _____
DOB _____
SS# _____

I give permission to the persons listed below to receive Private Health Information. I understand this form is legally binding and that I may revoke my authorization at any time by submitting my request to change, add or terminate such permission in writing.

Date of Permission	Name of Individual	Date Permission Revoked	Patient Initials

Comments or limitations on above:
_____
_____
_____.

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

Patient Identifier/Password: _____

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Printed Name of Patient or Guardian Relationship (If not self)