Permission to Discuss Protected Health Information

Patient Name: _____ Date of Birth _____

I hereby give my permission to the person(s) listed below to receive information about the medical care of the above named patient: (Please include both parents' names)

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

I have read the HIPAA Consent form and Notice of Privacy Practices and I agree with the terms of this notice.

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

Patient Identifier: _____ (Patient's Date of Birth)

Signature of Patient or Parent or Legal guardian (minor) Date