**PERMISSION TO DISCUSS PHI**
**(PROTECTED HEALTH INFORMATION)**

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/PHONE NUMBER |
| --- | --- |
| ______________________________ | ______________________________ |
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_____________________________________
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.