Permission for Release of Protected Health Information

Date

Patient Name **Date of Birth**
/ /

Message Authorization

If we need to contact you, may we leave a message at your

Home Telephone Number ____Yes ____No ( ) ________________________

Cell phone Number ____ Yes ____No ( ) ________________________

Work Phone Number ____ Yes ____ No ( ) ________________________

Request for Special Permission

I understand that my provider may use or disclose my protected health information (PHI) for the purpose of treatment, payment and health care operations. My provider may also disclose information to someone involved in my care or the payment for my care, such as a family member or friend

I hereby permit the provider to disclose this information to the following people

Persons Name	**Relationship**
______________________________________	______________________________________
______________________________________	______________________________________
______________________________________	______________________________________

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Signature of Patient or authorized representative **Date**