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PERMISSION TO DISCUSS PATIENT HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Please check one of the following:

- ❑ I hereby give my permission to have my medical information left on my voicemail.
- ❑ I hereby give my permission to the person(s) listed below to receive information about the care of the above named patient:

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____

_____
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.

Patient Identifier: _____