

PERMISSION TO DISCUSS PHI

Patient's Name: _____ **Date of Birth:** _____

I hereby give my permission to the person(s) listed below to receive information about my care of the above name patient:

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

(SIGNED) _____
Signature of Patient, Parent or Guardian

(DATE) _____