CHURCHLAND FAMILY MEDICINE

Permission to Disclose Private Health Information (PHI)

Patient Name:_____
DOB:_____

By signing below, I give permission to the person/persons listed to receive Private Health Information or other authorization as listed in the comments section. I understand this form is legally binding and that I may revoke my authorization at any time by submitting a written request to change, add or terminate

Date of Permission	Name of Individual	Comments

Signature of Patient or Legal Guardian

_____

Printed Name_____ Date_____