Patient Medications (please list with reason for use)

_____ _____

_____ _____

_____ _____

_____ _____

Permission To Discuss PHI

Patient Name _____ Date of Birth _____/_____/_____

If you would like our physician and staff to discuss your personal health information with someone other than yourself, please list names below.

NAME RELATIONSHIP

_____ _____

_____ _____

_____ _____

_____ _____

_____
Signature of Patient, Parent, or Guardian

_____
Date

Permission to leave detailed message of appointments, pathology, and/or test results on:

Home phone (_____) _____-_____ _____
Signature

Cell phone (_____) _____-_____ _____
Signature

In order to obtain information by telephone, anyone other than the patient must share the patient identifier with the staff.

Patient Identifier (word, phrase, numbers, etc.) _____