

## Protected Health Information Release (PHI)

**The name(s) listed below are individuals to whom I wish to grant access to my health care and/or billing information, as they deem necessary. I understand that information is limited to verbal discussion and that no paper copies of my Private Health Information (PHI) will be provided without my signature to release any "sensitive" information. I understand that authorizing the disclosure of this information to the below individuals is voluntary.**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information up to date. I understand that the revocation will not apply to any information that has already been released.

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_