



Saint Alphonsus

Protected Health Information Release

Please initial all applicable boxes and fill in any blank spaces where information is requested.

- Only release information to me personally.
- You have my permission to speak with my spouse about my medical care.
- You have my permission to leave information on my answering machine regarding my medical care and test results.
- You have my permission to talk with my children or other family members involved with my medical care.

Name _____ Phone _____

Relationship _____

Name _____ Phone _____

Relationship _____

Name _____ Phone _____

Relationship _____

Name _____ Phone _____

Relationship _____

Other, please describe _____

Patient Signature

Date

Place Patient Sticker here or handwrite
Name: _____
DOB: _____