



PROTECTED HEALTH INFORMATION RELEASE: PATIENTS 18 YEARS AND OLDER

Please check 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/Significant Other about my medical care and test results.
Spouse/Significant Other's Name _____ Phone _____
- 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 _____
- You have my permission to leave information on my answering machine regarding my medical care and test results.
- Other, please describe: _____

Emergency Contact:

Last Name _____ First Name _____ Phone Number _____
 Address _____ City _____ State _____ Zip _____
 Relationship to Patient _____

Patient Contact:

Patient Email _____
 Phone (Home) _____ Phone (Cell) _____
 Phone (Work) _____ Preferred Message/Contact Phone: Home Cell Work

 Patient Signature _____ Date _____ Time _____

People assisting with paperwork:

 Interpreter's name _____ Interpreter's Signature and/or ID # _____ Date and Time _____

 Office Staff's name _____ Office Staff Signature _____ Date and Time _____

Place patient sticker here or handwrite

Name _____

DOB: _____

HAVE PATIENT/GUARDIAN DATE AND INITIAL:

Reviewed _____	Reviewed _____
Date/Time/Initials	Date/Time/Initials
Reviewed _____	Reviewed _____
Date/Time/Initials	Date/Time/Initials
Reviewed _____	Reviewed _____
Date/Time/Initials	Date/Time/Initials