Print Form

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Permission to release PHI (personal health information)

According to the HIPAA guidelines we must have your signature to release any and all medical information. Should you have any testing done in our office, we will need your permission to release your results to anyone other than yourself. This includes your spouse, children and other medical offices. Please sign below and list all persons whom we have permission to discuss your medical records with, if their name is not listed we will not release any information. As well, we need your permission to leave message at your home or work with regards to appointments, financial matters or any other business conducted with our office. We apologize for any inconvenience. Please contact this office if there are any changes to this list.

Patient's Name:_____

Person's Name:_____

Person's Name:_____

Person's Name:_____

Signature of patient; if minor, signature of parent or guardian below:

_____

Date:_____

LOG TO TRACK DISCLOSURE OF PHI

Date	Description of PHI	Who Requested	Approve/Deny	Reason of Denial

NOTE: The practice must retain documentation and tracking log for each patient for six (6) years from the date of its creation or the date when it last was in effect, whichever is later.