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### 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 \_\_\_\_\_

Date \_\_\_\_\_

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