



BON SECOURS MEDICAL GROUP

**Permission to Disclose Private Health Information (PHI)**

Place patient label inside box (if no patient label, complete below)

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

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

MR #: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Social Security #: \_\_\_\_\_

By signing this paper below, I give permission to the person(s) listed in the table documented to receive Private Health Information or other authorization as listed in the comments section. I understand this form is legally binding and that I may revoke my authorization at any time by submitting by request to change, add, or terminate such permission in writing.

Date of Permission	Name of Individual	Comments/Instructions (i.e.; may pick up meds)	Parent/Guardian Initials	Date Permission Revoked	Parent/Guardian Initials	Telephone Number

In order to obtain information by telephone, the party calling the practice must be able to share the patient identifier/password with the staff.

Patient Identifier/Password: \_\_\_\_\_

Signature of Patient or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Printed Name of Patient or Legal Guardian \_\_\_\_\_ Relationship (if not self) \_\_\_\_\_



BON SECOURS MEDICAL GROUP

**Permission to Disclose Private Health Information (PHI)**

Place patient label inside box (if no patient label, complete below)

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

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

MR #: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Social Security #: \_\_\_\_\_

By signing this paper below, I give permission to the person(s) listed in the table documented to receive Private Health Information or other authorization as listed in the comments section. I understand this form is legally binding and that I may revoke my authorization at any time by submitting by request to change, add, or terminate such permission in writing.

Date of Permission	Name of Individual	Comments/Instructions (i.e.; may pick up meds)	Parent/Guardian Initials	Date Permission Revoked	Parent/Guardian Initials	Telephone Number

In order to obtain information by telephone, the party calling the practice must be able to share the patient identifier/password with the staff.

Patient Identifier/Password: \_\_\_\_\_

Signature of Patient or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Printed Name of Patient or Legal Guardian \_\_\_\_\_ Relationship (if not self) \_\_\_\_\_