DERMATOLOGY
Center of Richmond

Permission to Disclose Private Health Information (PHI)

Patient Name_____ DOB_____

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

Name of person	Relationship	Phone no	Home/work/mobile?

Printed Name of Patient or Legal Guardian_____

Relationship (if not patient)_____

Signature of Patient or Legal Guardian_____

Date_____

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