DERMATOLOGY
Center of Richmond

Dermatology Center of Richmond, P.C.
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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 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.

Name of Individual	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.

Printed Name of Patient or Legal Guardian_____

Relationship (if not patient)_____

Signature of Patient or Legal Guardian_____

Date_____