WEST IDAHO ORTHOPEDICS & SPORTS MEDICINE

PROTECTED HEALTH INFORMATION (PHI) RELEASE

Please check all applicable boxes and complete any blank spaces where information is requested

☐ You have permission to speak with my Spouse/Significant Other about my medical care and test results.

Spouse/Significant Other's Name _____ Phone _____

☐ You have my permission to talk with my children or other family members involved with my medical care.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

☐ You have permission to leave information on my answering machine regarding my medical care and test results.

☐ Other, please describe _____

Upon written request, I may limit the amount of time that this consent for release of information is valid. I may revoke this authorization, in writing, at any time. I understand that the revocation will not apply to information that has already been released. I understand that authorizing the disclosure of this information is voluntary.

Patient Name _____ Date of Birth _____

Signature _____ Date _____