MEDICAL RECORD ACCESS PERMISSION FORM

PROTECTED HEALTH INFORMATION

Please indicate below any persons that are permitted to have access to your protected medical information (e.g., lab results, medical records, x-ray reports, billing records, etc.) Also, please note any exceptions to medical information that can be released (For example, "**Do not release information about lab tests.**").

☐ I do not wish to list any individuals.

NAME: _____
RELATIONSHIP: _____
PHONE NUMBER: _____ Date of Birth: _____
EXCEPTIONS: _____

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NAME: _____
RELATIONSHIP: _____
PHONE NUMBER: _____ Date of Birth: _____
EXCEPTIONS: _____

_____
Patient Name (PRINT)

_____ _____ _____
Signature: Patient/Personal Representative Date Expire Date

_____ _____
Patient Social Security Number Patient Date of Birth

_____ _____
Name of Personal Representative Relation to Patient or Authority to Act