BON SECOURS MEDICAL GROUP
Bon Secours Richmond Health System

Permission to Disclose Private Health Information (PHI)

Patient Name: _____ DOB: _____

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) _____