Authorization to Verbally Discuss Protected Health Information (PHI)

Patient Name: ________________________ Patient DOB: ________________ Chart Number: ___________

I hereby give permission for representatives of Capital Area Orthopedic Associates to discuss my Protected Health Information (PHI) with the following individual(s):

Relative

Name of Relative: ____

Identification: ____

Power of Attorney Name: ____

Identification: ____

Other Individual Name: ____

Identification: ____

*Identification may be in the form of a birth date, social SSN or any other means of verifying validity of individual.

This Protected Health Information Form will stay in effect until you notify us to the contrary. If you want this form to expire on a particular date please indicate what date you request.

Date of Expiration: ____________________

Signature: ____ Date: _________________________

Witness: ____ Date: _________________________