Disclosure of Protected Health Information (PHI)

Patient Name: ___________________________ DOB: ____/____/____ Acct No. ____________

I hereby give my permission to the staff of North Country Orthopaedic Group to discuss and disclose my Protected Health Information (PHI) with the following persons:

Name: ____________________________________ Address: ____________________________
Relationship: _______________________________ ____________________________
Phone #: __________________________________ ____________________________

Name: ____________________________________ Address: ____________________________
Relationship: _______________________________ ____________________________
Phone #: __________________________________ ____________________________

Name: ____________________________________ Address: ____________________________
Relationship: _______________________________ ____________________________
Phone #: __________________________________ ____________________________

Name: ____________________________________ Address: ____________________________
Relationship: _______________________________ ____________________________
Phone #: __________________________________ ____________________________

Name: ____________________________________ Address: ____________________________
Relationship: _______________________________ ____________________________
Phone #: __________________________________ ____________________________

____ ____/____/____

Patient Signature (or Parent/Legal Representative) Date