NORTH COUNTRY
ORTHOPAEDIC GROUP ™

Disclosure of Protected Health Information (PHI)

Patient Name _____ **Date of Birth**_____

Address _____ **Phone #** _____

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 person(s):

Name: _____ Address: _____

Relationship: _____ _____

Phone #: _____ _____

Name: _____ Address: _____

Relationship: _____ _____

Phone #: _____ _____

Name: _____ Address: _____

Relationship: _____ _____

Phone #: _____ _____

Name: _____ Address: _____

Relationship: _____ _____

Phone #: _____ _____

Name: _____ Address: _____

Relationship: _____ _____

Phone #: _____ _____

Please note: To enable the above-named individual(s) to pick up and/or obtain copies of medical records, a 'Patient Authorization to Release Protected Health Information (PHI)' form will also need to be completed.

_____ _____

Signature of Patient, Parent or Legal Guardian Date

_____ _____

Printed Name of Patient, Parent or Legal Representative Relationship/Authority

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