COMMONWEALTH PRIMARY CARE

Physician/Location (select one): ☐ Forest ☐ Glen Forest ☐ Huguenot ☐ Ridgefield ☐ Three Chopt ☐ Wyndham

PERMISSION TO DISCUSS PHI

Name: ____________________________ Date of Birth: ____________________________

Account Number:____________________

I authorize Commonwealth Primary Care and it's agents to release my protected health information to the following individuals:

Name	Relationship	Phone Number
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

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Signature of Patient, Parent or Guardian

____
Date

In order to obtain information by telephone, the party calling the practice must share the patient identifier with the staff.

Patient Identifier: ________________________________