



2232 Wilborn Avenue, South Boston, VA 24592

Telephone: (434) 572-8977 Fax: (434) 572-2510

PERMISSION TO DISCUSS PERSONAL HEALTH INFORMATION (PHI)

Patient Name: _____

Date of Birth: _____

Account Number: _____

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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: _____ (Patient Date of Birth)