COLONIAL ORTHOPAEDICS

PERMISSION TO DISCLOSE PRIVATE HEALTH INFORMATION (PHI)

Patient's Full Name _____

Date of Birth _____ Social Security # _____

By signing this PERMISSION TO DISCLOSE PRIVATE HEALTH INFORMATION, I give permission to the person(s) listed below to receive PHI or other authorization as indicated. I understand that this form is legally binding and that I may revoke my Authorization at any time by submitting my request to change, add, or terminate such permission in writing.

Date	Name of Individual	Comments/Instructions	Patient/ Guardian Initials	Date Permission Revoked	Patient/ Guardian Initials

To obtain information by telephone, the party calling Colonial Orthopaedics must be able to share the patient identifier/password with the staff.

Patient Code Word _____ Printed Name of Patient or Legal Guardian _____

Signature of Patient or Legal Guardian _____ Relationship _____ Date _____

Code Word declined ☐

This form will expire one (1) year from the date of signature.