HIPAA Approved Contacts

Please list the individuals you give permission to have access to and discuss your protected health information:

NAME	Date of Birth	Phone #	Relationship
_____	__/__/__	(___) ___ - ___	_____
_____	__/__/__	(___) ___ - ___	_____
_____	__/__/__	(___) ___ - ___	_____
_____	__/__/__	(___) ___ - ___	_____

This form will remain in effect until a written request is received to change or an updated form is filled out by you.

_____ _____

Patient Name Account Number

_____ _____

Patient / Legal Guardian Signature Date