Permission for Patient Health Information (PHI) Communications

Print Name: DOB:

Address:

Phone Number:

I permit Upper Hand Orthopaedics, their physicians, medical assistants, and other personnel ("Health Care Providers") to discuss health information, in person or by telephone, with the following family members or friends involved in my medical care:

(List family members/friends and state the person's relationship to the patient)

This authorization is limited to the following time frame: One year from date signed

Does not expire

If, at any time, I do not want verbal discussion to be permitted between my Health Care Providers and any of the individuals named above, I must notify my Health Care Provider by contacting Upper Hand Orthopaedics.

Patient's signature_____ Date:_____