



# Tri-Area Community Health

Tri-Area Community Health Centers

866-942-0401 Phone  
276-398-3331 Fax

## AUTHORIZATION FOR PERMISSION TO DISCUSS PROTECTED HEALTH INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby give my permission to the person(s) listed below to receive information about my care:

NAME	RELATIONSHIP	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

\_\_\_\_\_  
Signature of Patient, Parent or Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date