DOCUMENT GRANTING INDIVIDUALS PERMISSION TO PATIENT'S PHI

I, _____ grant the following
Print Patient Name

person(s) access to my personal health information:

NAME RELATIONSHIP

_____

_____

_____

_____

_____

_____

[ ] Check box if also granting access to your patient portal.

I understand that any changes to this document must be submitted in writing or a new form updated and signed. This authorization is effective for five years from the date signed unless otherwise indicated.

_____

Patient Signature Today's Date