THOMASVILLE PEDIATRICS
ARCHDALE-TRINITY PEDIATRICS
THOMASVILLE-ARCHDALE PEDIATRICS WELL-CHILD CLINIC
MIDWAY PEDIATRICS

PERMISSION TO DISCUSS PATIENT HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I hereby give my permission to the person(s) listed below to receive information about the care of the above-named patient:

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I HAVE READ THE CONSENT FORM AND NOTICE OF INFORMATION PRACTICES AND I AGREE WITH THE TERMS IN THIS NOTICE.

In order to obtain information by telephone, the party calling the practice must share the patient identifier with the staff.

Patient Identifier: (Patient Date of Birth): _____