Tri County Internal Medicine, P.C.
Request for Release of Protected Health Information (PHI)

If you wish to have any of your protected health information released to any family members or friends, then you must list those individuals on this form. **WE CANNOT SPEAK TO ANYONE ABOUT YOUR PROTECTED HEALTH INFORMATION IF THEY ARE NOT LISTED ON THIS FORM.** You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

*****PLEASE NOTE:** Tri County Internal Medicine, P.C. is not required to agree to your request. Please see our Notice of Privacy Practices for more information regarding such requests.

Patient's Name: _____ **Date of Birth**: _____

May we call, text, or email you appointment information? ☐ Yes ☐No

I authorize the disclosure of my Protected Health Information (such as test results, prescription information, appointment information, referral information, medical diagnoses, billing information, etc.) to the following individuals:

Name: _____

Relationship to Patient: _____

Phone Number: _____

Name: _____

Relationship to Patient: _____

Phone Number: _____

Name: _____

Relationship to Patient: _____

Phone Number: _____

Name: _____

Relationship to Patient: _____

Phone Number: _____

Signature of Patient: _____ **Date:** _____
(or signature of Legal Guardian if patient is a minor or an incapacitated adult)