EAST BAY BRAIN & SPINE
MEDICAL GROUP

PROTECTED HEALTH INFORMATION (PHI) PERMISSIONS

This form gives East Bay Brain & Spine Medical Group permission to discuss your protected health information (PHI) with others.

Patient Name:	Patient DOB:

Please list below the individuals you give us permission to discuss your medical/health information (PHI) with.

Individual Name:	Relationship to you:	Phone Number:
1.		
2.		
3.		
4.		

I hereby gran East Bay Brain & Spine Medical Group and anyone employed by it, permission to discuss my medical/health information (PHI) with any of the individuals listed above. Any and all prior designations are hereby revoked.

_____	_____	_____
Signature of Patient/Legal Representative/ Spouse/Financially Responsible Party	*Date/Time*	*Relationship to Patient*