FORT WORTH
MEDICAL SPECIALISTS

Dr. Greg Phillips // Lacy Voth PA-C

HIPAA RELEASE FORM

Patient Name _____

_____

Signature **Date**

Privacy regulations require us to have releases signed by our patients for us to speak with Family members, friends and other relations regarding medical treatment. Each person must be listed individually and by name.

Please print name, relationship and telephone number for each person to whom you are authorizing release of your private health care information.

Name	**Relation**	**Telephone #**
Name	**Relation**	**Telephone #**
Name	**Relation**	**Telephone #**
Name	**Relation**	**Telephone #**