MICHAEL R. MARCH, M.D., P.A.
Obstetrics and Gynecology

PERMISSION TO DISCUSS PHI

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
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____
Signature of Patient, Parent or Legal Guardian

_____
Date

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