FRONTIER
DERMATOLOGY

PERMISSION FOR PATIENT HEALTH INFORMATION (PHI) COMMUNICATIONS

I permit Frontier Dermatology, their physicians, medical assistants, and other personnel ("Health Care Providers") to discuss health information, in person or by telephone, with the following family members or friends involved in my medical care:

(List family members/friends and state the person's relationship to the patient below).

NAME	DATE OF BIRTH	PHONE NUMBER	RELATIONSHIP
1.			
2.			
3.			
4.			

This authorization will expire: ☐ 1 year from the date the signed
☐ 3 years from date the signed

If, at any time, I do not want verbal discussion to be permitted between my Health Care Providers and any of the individuals named above, I must notify my Health Care Provider by contacting Frontier Dermatology.

This is a legal document and by signing, you agree that you understand and accept the terms on this form.

_____ _____
Patient Name **Patient Date of Birth**

_____ _____
Patient Signature **Date**

INSTRUCTIONS

Bring this form to your appointment along with your new patient paperwork; or print, sign and mail to:

Frontier Dermatology - Medical Records
1793 13th St SE
Salem, OR 97302

Phone: 866-599-3376
Fax: 503-362-8435