933 NW 25th Ave

Portland, OR 97210
p. 503.525.0090
f. 971.244.0219
Pearlhealth.center

Authorization to Communicate PHI

Patient Name: _____
Date: _____
Provider: _____

I hereby authorize The Pearl Health Center Provider(s) and Medical Staff to communicate with the following individual(s) regarding my medical status and/or conditions:

_____	_____	_____
Name	Relationship	Phone Number

☐ hereby revoke this authorization on _____

_____	_____	_____
Name	Relationship	Phone Number

☐ hereby revoke this authorization on _____

_____	_____	_____
Name	Relationship	Phone Number

☐ hereby revoke this authorization on _____

☐ hereby revoke this authorization on _____

Patient Signature: _____ Date: _____