Washington University in St.Louis
SCHOOL OF MEDICINE

General Thoracic Surgery

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Patient NAME:_____

Date of Birth: _____

Authorization

TO DISCUSS MY PROTECTED HEALTH INFORMATION (PHI)

I authorize Washington University Thoracic Surgery, Physician and/or staff to discuss my Protected Heath Information (PHI) with the people listed below. This authorization allows us to give your test results and discuss your care with the people you designated (children, parents, siblings, friends, etc.).

1.) _____

2.) _____

3.) _____

4.) _____

5.) _____

6.) _____

_____ _____

Patients Signature **Date**