Authorization for Verbal Communication

Confidentiality is very important to us. Often family members inquire about health status or wish to be involved in the patient's treatment. Sometimes age specific conditions require that a family member or others assist with your health care. **Unless you tell us otherwise, our standard policy is to NOT provide any information.** By completing this form, you give us permission to **verbally** discuss your information with whomever you choose. Feel free to discuss this with your physician or other clinic staff member.

Note: *For patients who are minors, both parents may have access to all information unless forbidden by divorce decree.*

Patient Name: ______________________ Date of Birth: ____________

Name: ______________ **Relationship:** ____________ **Phone:** ____________

☐ Any aspect of my health care ☐ Health information only ☐ Financial information only

Name: ______________ **Relationship:** ____________ **Phone:** ____________

☐ Any aspect of my health care ☐ Health information only ☐ Financial information only

Name: ______________ **Relationship:** ____________ **Phone:** ____________

☐ Any aspect of my health care ☐ Health information only ☐ Financial information only

Name: ______________ **Relationship:** ____________ **Phone:** ____________

☐ Any aspect of my health care ☐ Health information only ☐ Financial information only

Name: ______________ **Relationship:** ____________ **Phone:** ____________

☐ Any aspect of my health care ☐ Health information only ☐ Financial information only

I, the undersigned, authorize and give permission to my health care team to VERBALLY discuss the indicated information above with the individuals(s) I have listed. I understanding that this form does NOT give the listed individual(s) permission to make health care decisions for me.

xSignature ______________ ________ Relationship, if signed by other: ______________

Date (Parent, if minor child, or guardian)