Healthcare Permission for Verbal Communications and/or to Leave Messages

Patient Information

Name of patient or patient label _____ Date of birth _____

Street address _____ City, state, zip code _____

Phone number _____ Patient MRN _____

Authorization

I authorize the verbal disclosure of my medical information. This document does not authorize the release of any written health information.

Unless indicated otherwise below, this authorization includes disclosure of information regarding developmental disabilities, alcohol or drug treatment, AIDS or AIDS-related illness, and financial information such as account balance and payment intentions (if applicable).

If at any time, I wish to revoke any authorizations included on this form, I must contact the Health Information Department of the organization that received this form.

Permission for Verbal Communications

I allow communication between ☐ any healthcare provider or ☐ _____
Name of specific healthcare facility/facilities

and _____ _____ _____
Print name of individual | Phone number | Relationship to patient
Please complete additional forms if designating more than one individual

I allow voice messages to be left at the following phone number(s): _____
Number can be for self or the above individual

☐ I wish to exclude the following medical conditions from verbal communications (if any): _____

_____

☐ I wish to exclude the disclosure of financial information such as account balance and payment intentions

☐ I wish to limit this authorization to the following time frame: from _____/____/_____ to ____/____/_____
If no dates are indicated, this form will remain in effect for an unlimited amount of time.

Signature _____ **Date** _____

If this Authorization is signed by a representative on behalf of a patient, please complete the following:

Representative's name (please print) _____ **Relationship to patient** _____

WILDWOOD FAMILY CLINIC, S.C.

"HEALTHCARE FOR ALL AGES"

About this Form:

Wildwood Family Clinic health care providers and staff recognize confidentiality as a very important part of your relationship with them. To protect your privacy, they will not routinely speak to individuals or leave messages regarding your healthcare treatment unless you specifically give permission to do so. This authorization allows health care providers and staff to share health information as you specify.

By completing the reverse side of this form, you can authorize any combination of the following:

1. Permission for verbal communication (both in person and on the telephone) between your health care team and the person listed on the form.

2. Permission to leave voice mail messages regarding your care at a specific phone number.

If you wish to limit the types of health information that health care providers and staff may share, you can indicate so on the reverse side of this form.

Return Instructions:

Please complete, sign, and return this form to your care team during your appointment today.

Office Use:

MRN# _____

Staff Initials: _____