Consent for Verbal Communication of Medical Information

☐ I authorize the discussion of my medical record information including the diagnosis, findings of exams and procedures; and billing claims information. Please limit to 3 contacts.

1. Name: ___________________________ Ph: __________ Relationship: ___________________________

2. Name: ___________________________ Ph: __________ Relationship: ___________________________

3. Name: ___________________________ Ph: __________ Relationship: ___________________________

☐ Information is not to be discussed with anyone.

This Consent for Verbal Communication of Medical Information will remain in effect until terminated or changed by me in writing.

Messages

Please call my: ☐ Home: _________________ ☐ Work: _________________ ☐ Cell Number: _________________

If unable to reach me:

☐ Please leave a message asking me to return your call

☐ Other, please specify __________________________

Signed: _____________________________________ Date: __/__/____ Time: _________ AM PM

Print Name: __________________________________

Send Completed Form to the HIM Department for Scanning