

Verbal Communication Release Form



Our patients often want us to verbally communicate with family or friends who are assisting them in their treatment or payment for treatment. Please list below any family or friends with whom you authorize us to discuss your treatment/care or billing information.

Only Me

Name (printed)
Treatment/Care: Yes No
Billing Information: Yes No

Relationship

Name (printed)
Treatment/Care: Yes No
Billing Information: Yes No

Relationship

Name (printed)
Treatment/Care: Yes No
Billing Information: Yes No

Relationship

Name (printed)
Treatment/Care: Yes No
Billing Information: Yes No

Relationship

This authorization will remain in effect for a period of one year unless you revoke it. This authorization is for verbal communication only. If you want someone to have a copy of your medical records, please request a medical release form. There may be a charge for copies of your medical records.

Patient's Name (printed)

Date of Birth

Patient's Signature

Date

Authorized Representative
Relationship to Patient _____

Date