ORAL COMMUNICATION RELEASE

I, _____, date of birth_____, give my authorization to my physician/physician's staff to discuss any medical issues concerning me to the following individuals.

	Name
_____My spouse	_____
_____My son, daughter, children	_____
_____My caregiver	_____
_____Other	_____

I, _____, also give my physician/physician's staff permission to leave a message on my home answering machine or to any person answering my home phone and/or permission to contact my cellular telephone and leave a message on my voicemail.

I, _____, also give my permission to my physician/physician's staff to contact me at my place of employment. If I am unable to be reached there, I give my permission to my physician/physician's staff to leave a message for me to return their call.

If there is any medical information I do not want to be discussed or a message to be left at my home or at my place of employment, I will notify my healthcare provider staff of this in writing. If there is any change in information pertaining to this consent, I will also notify my healthcare provider of this in writing.

I, _____, also give my permission to my physician/physician's staff to fax any information regarding me to another physician's office that may be covering for my healthcare provider staff, or a physician I may be referred to by my healthcare provider staff.

I, _____, also give my permission to my physician/physician's staff to contact my pharmacy, which is
_____ (pharmacy/city) regarding my prescription(s).

I may cancel this consent and time by doing one of the following:

1) Signing and dating a form that my physician/physician's staff can provide to me called a "Revocation of Consent for Use and Disclosure of Health Care Information" or
2) Writing, signing, and dating a letter to my physician/physician's staff. If I write a letter, it must state that I want to revoke my consent to authorize the use and disclosure of a patient's health information for treatment, payment, and health care operations.

The purpose of this release is to ensure you that this facility understands the requirements to provide medical care that will meet the federal laws as required by the Health Insurance Portability and Accountability Act (HIPAA) and any and all other Federal regulation and interpretive guidelines.

Each portion of this form must be filled out and signed if you want to delegate anyone to have access to your Protected Health Information. If we do not have this form on file, no information will be released.

If you do not want anyone to have oral access to your Protected Health Information under any circumstances, please sign write NONE at the end of this line and date and sign on the line below this section.

_____

Signature of Patient **Date**

_____

Signature of Patient Representative **Relationship of Patient Representative to Patient**