Authorization For Verbal Communication of Protected Health Information

Name:	Date of Birth:
Address:	Telephone:
City	State/Zip Code

I permit Laurel Medical Group, their physicians, nurses and other personnel to discuss my health information, in person or by telephone, with the following family members or others directly involved in my medical care.

Name	**Phone Number**	**Relationship**
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Release of information under this document is limited to verbal discussion with my Healthcare Providers. **This document does not permit release of any written health information to the individuals named above.**

This authorization will expire in 1 year from signature unless otherwise indicated below:

__ Indefinite (Never expires or until minor child reaches the age of 18)

__ Ends on (date) _____

I understand that:

- I may revoke this authorization at any time in writing. My revocation will not apply to information already obtained.
- Unless the purpose of this authorization is to determine payment of a claim or benefit, the provision of treatment or payment for my care may not be conditioned upon my signing the authorization.
- **The information authorized for release may include information which may indicate the presence of a communicable or non-communicable disease.**
- The information authorized for verbal release may include protected health information related to mental health. Release of mental health record may require consent of the treating physician.
- The information authorized for verbal release may include drug/alcohol abuse treatment records.

_____ _____ _____

Signature of Patient/Legal Representative Relationship Date