

## CONSENT FOR VERBAL RELEASE OF INFORMATION

1. Please list your preferred numbers:

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

2. Which phone number is best to use during the day (8am – 4pm)?  Home  Cell  Work

3. Which phone number is best to use in the evening (4pm – 7pm)?  Home  Cell  Work

4. Check box if we may leave detailed messages, including appointment reminders, on your voicemail\*.

Home  Cell  Work

5. Check box if we may leave detailed lab/test results on your voicemail\*.

Home  Cell  Work.

\* Answering machines and voice mail must have an identifying message to confirm these are your numbers for example; "You have reached John Doe"

6. Please list your preferred pharmacy:

Pharmacy Name: \_\_\_\_\_

Pharmacy location and/or Phone: \_\_\_\_\_

7. Please list any persons with whom we MAY share details about your health care. Indicate below whether this may include sensitive health information (SHI) such as mental health, developmental disabilities, AIDS/HIV or other STD treatment and/or diagnosis, Drug/Alcohol abuse diagnosis, treatment and/or referral and Genetic Testing.

NAME	RELATIONSHIP	RELEASE SHI?	
		Yes	No
		Yes	No
		Yes	No
		Yes	No
		Yes	No

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Printed name: \_\_\_\_\_

Patient, Parent or Guardian

