

Permission for Verbal Communication

MFN:

Patient Identification

Patient Name

Date of Birth

Phone Number (s)

Full Address (City, State, and Zip Code)

I permit **Baylor Scott & White Health** physicians and staff to discuss my personal medical health information, in person and/or by telephone, with the following family members and/or friends involved in my medical care for the following purposes:

- To orally schedule or confirm my appointments;
- To discuss results of diagnostic tests, diagnosis, prognosis, and treatment plans; or
- To discuss billing and payment for medical services

I understand that this document applies to all departments, healthcare providers and/or employees with **Baylor Scott & White Health**. I understand that this authorization is voluntary and that once this information is disclosed to the person(s) designated that it may be re-disclosed by them and may no longer be protected by state or federal privacy laws.

Name

Relationship

Phone Number

1. _____
2. _____
3. _____

I further understand that I may revoke this authorization at any time by sending a written statement of revocation to **Baylor Scott & White Health – HIM Department**.

This document of Permission for Verbal Communication will expire upon revocation, or at the date or event specified here _____.

This document does not permit the release of written information to these individuals. My refusal to sign this authorization will not negatively affect my health care at **Baylor Scott & White Health**.

Patient Signature

Date

Patient's Representative on behalf of patient

Relationship to patient

Date

Witness (if patient has Representative sign)

Date