Authorization for Verbal Communications

Patient Name: ____ DOB: _____________________

Street Address: ____ City, State, Zip: _____________________

Email: ____________________________ ___________________ Phone Number: (_____)______________

I permit INTEGRIS Weight Loss Clinic, its physicians, nurses and other healthcare providers to verbally discuss my personal health information with the recipients listed below. Such communication may be in person or by telephone.

- ☐ NO, there are no limitations on what may be discussed regarding any medical conditions which the patient has received care.
- ☐ YES, there are limitations on what may be discussed regarding the following medical condition(s):____

Please list the names, phone numbers, and relationship to the patient of the people you authorize to receive verbal communications:

1. ____
2. ____
3. ____
4. ____

Release of information under this document is limited to verbal discussion with the recipients. This document does not permit release of any written information to the individuals named above. Should you desire to have written health information released to the recipients, an additional form must be completed.

This authorization will remain in effect for one year following the date of signature below.

If, at any time, you want to withdraw your authorization for INTEGRIS Health to have verbal discussions with the recipient, you must update this authorization form in writing.

Patient Signature: ____ Date: _______________

If this release is signed by a legal Representative (i.e., Health Care Proxy, Durable Power of Attorney, or Guardian) please complete the following and provide a copy of the document appointment the Legal Representative for inclusion in the patient’s record.

Representatives Name: ____ Relationship: ________________