



Permission to Verbally Discuss Protected Health Information

Patient Name:	Date of Birth:
---------------	----------------

In some cases, patients may wish to have information regarding their medical condition(s), medications, scheduled appointments, lab results, etc. discussed with individuals involved in their care such as family members, friends or caretakers. If this applies to you, please indicate below any person with whom you would like us to share protected health information regarding your care.

I give permission to Elevate Health to verbally discuss information regarding my medical care to the following person(s):

Name	Relationship to Patient	Phone Number

I understand that I may cancel this permission at any time (in writing to Elevate Health) but that cancelling it will not affect any information that has already been disclosed.

I understand that I do not have to sign this form, and that I should only sign it if I want Elevate Health to share my information with someone.

This form is only for the release of verbal information and not for disclosure of medical records.

Patient Signature or Guarantor	Date
Description of Guarantor's Authority, if required:	