Permission to Verbally Disclose Protected Health Information

***Note: Completion of this form is optional. To be valid, this form must be filled out COMPLETELY, including the type of information you are granting us permission to share.**

Name: _____ DOB ____/____/_____ Date: ____/____/_____

. I give permission to Graser/Medina Podiatry & Bunion Surgery Institute to **VERBALLY** discuss the following medical and billing information about me (check all boxes that apply):

☐ Scheduling/Cancelling/ appointment information

☐ Medical information, including my symptoms, diagnosis, medications, and treatment plan.

☐ Lab/test results

☐ Billing and payment information

☐ Other: _____

To the following Entities:

Name	Phone	Relationship to Patient

I understand that I may cancel this permission at any time (In writing), but that cancelling it will not affect any information that has already been released.

I understand that I do not have to sign this form, and that I should only sign it if I want my medical provider or my clinic to share my information with someone.

This authorization expires:

☐ When I cancel it in writing OR _____ ***(specify date)***
If no expiration date is specified, this authorization will remain in effect until our office receives written notice to cancel it.

☐ I decline permission to verbally discuss medical information with anyone.

_____ _____
Patient Signature PT ID (office use)