Baylor Scott & White HEALTH

MRN:

Patient Identification

Permission for Verbal Communication

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