Verbal Communication Release Form

To: Patient of MAHEC_____

Many times our patients want us to verbally communicate with their family or friends who are assisting them in their treatment or payment for treatment. Please list below any family or friends whom you authorize us to discuss your care or billing information.

_____ _____
Name (printed) Relationship
Treatment/Care: Yes ❑ No ❑
Billing Information: Yes ❑ No ❑

_____ _____
Name (printed) Relationship
Treatment/Care: Yes ❑ No ❑
Billing Information: Yes ❑ No ❑

_____ _____
Name (printed) Relationship
Treatment/Care: Yes ❑ No ❑
Billing Information: Yes ❑ No ❑

This authorization will remain in effect for a period of one year unless you revoke it. This authorization is for verbal communication only. If you want someone to have a copy of your medical records, please request a medical release form. There may be a charge for copies of your medical records.

_____ _____
Patient's Name (printed) Date of Birth

_____ _____
Patient's Signature Date

_____ _____
Authorized Representative Date
(state your relationship to patient)