Signature of witness:____ Date:______________

AUTHORIZATION FOR VERBAL DISCUSSION OF HEALTHCARE INFORMATION

Patient: ____
FIRST NAME MI LAST NAME

Date of Birth: ___/___/______ Primary Phone: _______________ HOME CELL WORK
MM / DD / YYYY (CIRCLE ONE)

I give permission to Advanced Family Medicine to VERBALLY discuss the selected healthcare information about me with:

Name: ____
FIRST NAME MI LAST NAME

Primary Phone: ________________ HOME CELL WORK Relationship:___________________
(CIRCLE ONE)

Information Approved for Discussion:
(CHECK ALL BOXES THAT APPLY)

- ❏ Scheduling and Appointment information
- ❏ Medical information including symptoms, diagnosis, test results, and treatment plans
- ❏ Mental health information including symptoms, diagnosis, and treatment plans
- ❏ Drug/Alcohol Dependency and related treatment information
- ❏ HIV testing or diagnosis information
- ❏ Billing and Payment information
- ❏ Other (please describe):____

I give permission to Advanced Family Medicine to VERBALLY discuss the selected healthcare information about me with:

Name: ____
FIRST NAME MI LAST NAME

Primary Phone: ________________ HOME CELL WORK Relationship:___________________
(CIRCLE ONE)

Information Approved for Discussion:
(CHECK ALL BOXES THAT APPLY)

- ❏ Scheduling and Appointment information
- ❏ Medical information including symptoms, diagnosis, test results, and treatment plans
- ❏ Mental health information including symptoms, diagnosis, and treatment plans
- ❏ Drug/Alcohol Dependency and related treatment information
- ❏ HIV testing or diagnosis information
- ❏ Billing and Payment information
- ❏ Other (please describe):____

This authorization will remain in effect indefinitely or until a written notice to revoke or update the authorization has been received by Advanced Family Medicine. I have the right to change or revoke this authorization at ANY TIME except where Advanced Family Medicine has already made disclosures pursuant to this original request. **I understand that in order to change or revoke this authorization that I must submit a request in writing and complete a new Authorization for Verbal Discussion of Healthcare Information form.**

Patient or Guardian Signature:____ Date: _____________

This form authorizes verbal discussion of medical information only, to request a copy of medical records please complete the AFM Authorization for Release of Confidential Information Form.