INTEGRIS HEALTH

AUTHORIZATION FOR VERBAL AND CAREGIVER COMMUNICATIONS

_____ _____
Patient Name Birthdate

_____
Street Address City, State, Zip Code Phone Number

I permit INTEGRIS Health and its physicians, nurses, and other healthcare providers to discuss my personal health information with the recipients listed below. Such communications may be in person or by telephone.

☐ NO, there are no limitations on what may be shared regarding any medical condition for which the patient has received care.
☐ YES, there are limitations on what may be shared regarding the following medical condition(s):
Please list limitations:_____

Please list the names and phone numbers of the individuals you wish to receive verbal information:

	Name	Relationship	Phone Number
1.			
2.			
3.			

In addition to the individuals named above, we may also discuss your personal health information with friends and family involved in your care.
If there are any friends or family you would not want us to speak with, please list their name:

	Name	Relationship	Phone Number
1.			
2.			
3.			

This document does not permit release of written health information to the individuals named above other than after care documentation to facilitate transition of care. Should you desire to have additional written health information released to the recipients, the Patient Request for Health Information form must be completed.

The authorization will remain in effect for one year following the date of signature below. If, at any time, you want to with draw your authorization for INTEGRIS Health to have verbal discussions and caregiver communications with the recipients, you must update this authorization form in writing.

_____ _____ _____ _____
Signature Patient or Legal Representative **Print Patient or Legal Representative** **Date** **Time**

If this Release is signed by a Legal Representative: My authority as Legal Representative is as [check one]:

___Parent/Legal Guardian
___Durable Power of Attorney *(must provide a copy of the document appointing Legal Representative)*
___Health Care Proxy under Living Will *(must provide a copy of the document appointing Legal Representative)*
___Court-Appointed Guardian of the Person *(must provide a copy of the document appointing Legal Representative)*

Patient Label
Patient Name:
MRN:
DOB: