Sentara®

Physician Clinics
Verbal Release of Information

_____
EMR

Many of our patients allow family members such as their spouse, significant other, parents and/or children to call and request medical information, result of tests, procedures and financial information. Under the requirements for HIPAA, we are not allowed to give this information to anyone without the patient's consent.

If you wish to have information released to any family members/friends, you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Name: _____ Date of Birth: _____

I authorize the following Clinic to disclose: _____

Clinic Address:_____

To have contact with the following people to release information about my care and status/condition as it relates to:

- ☐ Medical information (all visit information to include lab results)
- ☐ Psychological state
- ☐ Past and future appointment dates
- ☐ Medications including prescription pick up
- ☐ Leaving detailed voicemails about my care or any above selected information

1. _____
Name Relationship/Phone

2. _____
Name Relationship/Phone

3. _____
Name Relationship/Phone

4. _____
Name Relationship/Phone

5. _____
Name Relationship/Phone

I understand this authorization is valid for one year and may be revoked or amended at any time.

_____ _____
Date/Time Patient Signature

_____
Other Responsible Party Signature Date/Time

_____
Relationship to Patient