Permission to Verbally Discuss Protected Health Information

Patient Name: ____ **Date of Birth:** ____________________

I give permission to Sidney Regional Medical Center to verbally discuss the following medical and billing information about me (initial all lines that apply)

______ Scheduling/appointment information

______ Medical information, including my symptoms, diagnosis, medications and treatment plan
(*This may also include information about sexually transmitted disease (STD) testing and treatment, HIV/AIDs testing and treatment, pregnancy testing, prenatal care, birth control and family planning, behavioral and mental health and chemical dependency.)*

______ Lab and Radiology results

______ Billing and payment information

______ Other: ____

SRMC has my permission to discuss the above information with:

Name	Phone	Relationship to Patient

*mark through any unused boxes above

I understand that I may cancel this permission at any time in writing, but that cancelling it will not affect any information that has already been released.

I understand that I do not have to sign this form and that I should only sign it if I want my medical provider to share my information with someone.

This authorization expires:
When I cancel it in writing **or**
Upon this date: ____________________________ (specify date)
If no expiration date is specified, this authorization will remain in effect until SRMC receives written notice to cancel it.

______________________________ ______________ ______________________________
Signature of patient/guardian Date Relationship to patient

______________________________ ______________ ______________________________
Witness if patient is unable to sign Date Relationship to patient