DIABETES & THYROID CARE

PERMISSION FOR VERBAL COMMUNICATIONS AND NOTIFICATIONS:

Authorization for in person or telephone disclosures:

I permit Diabetes and Thyroid Care, their doctors, nurses and other personnel to disclose my health information including billing and payment information, test results or lab results in person or by telephone, with the following family members or friends involved in my medical care. This may include information related to psychiatric care, drug and alcohol use, HIV testing and/or AIDS.

Limit discussions to the following medical condition (s) or service (s): _____

	Name:	Phone number:	Relationship:
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____

_____ None, I do not wish my information discussed with anyone other than myself.

Release of information under this document is limited to verbal discussions as indicated above and/or limited paper records or business office documents as necessary for my immediate assistance.

Lab test results, referrals and other instructions:

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For example, name of provider, type of physician (specialty), normal test results and instructions.
Allowed communication methods that you authorized for calls and for messages (check all that apply):

☐ Home phone/answering machine	_____	☐ Preferred method
☐ Cell phone/voicemail	_____	☐ Preferred method
☐ Work phone/voicemail	_____	☐ Preferred method
☐ Email address	_____	☐ Preferred method

This authorization does not expired unless revoked or updated. If at any time I do not want verbal discussions to be permitted between my healthcare providers or facility and any of the individuals amed above (provided that the information has not yet been released) or change in my method of communication, I must notify Diabetes & Thyroid Care.

_____	_____	_____
Signature of Patient/Patient's representative	Printed name of person signing	Date

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