AUTHORIZATION FOR VERBAL RELEASE OF MEDICAL INFORMATION TO OTHERS

Patient Information

Legal Name: First_____ MI_____ Last_____

DOB: _____

Address: _____Apt # _____ City_____ State_____ Zip _____

Phone: Home_____ Work_____

Mobile_____

I authorize the release of information to the following individuals.

Effective Date _____

Name _____ Relationship to Patient_____

Home Phone_____ May We Leave a Message? □ Y □ N

Mobile_____ May We Leave a Message? □ Y □ N

You may release the information regarding the following services to the person named above: ☐ Appointments ☐ Billing ☐ Medical Care

Name _____ Relationship to Patient_____

Home Phone_____ May We Leave a Message? □ Y □ N

Mobile_____ May We Leave a Message? □ Y □ N

You may release the information regarding the following services to the person named above: **☐ Appointments ☐ Billing ☐Medical Care**

I authorize Texas Health and its representatives to use the additional contact information listed above to discuss or disclose information regarding any matters relating to my appointments, billing information and/or medical care as indicated. This authorization will remain in effect until I provide written notification to Texas Health of changes or updates.

I have read, fully understand, and agree to the above release of medical information to others.

Patient Printed Name _____

Patient Signature _____ Date_____

FACILITY NAME MUST BE FILLED IN BLANK BELOW

THPGAUTHOTH

Texas Health

_____

Patient Name: _____
DOB: _____
MRN: _____

Authorization to Verbally Release Information - Others