

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



TPHGAUTHOTH



Patient Name: _____

DOB: _____

MRN: _____

Authorization to Verbally Release Information - Others