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? ❑ Yes ❑ No

Mobile: _____ May We Leave a Message? ❑ Yes ❑ No

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? ❑ Yes ❑ No

Mobile: _____ May We Leave a Message? ❑ Yes ❑ No

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: _____ DOB: _____

Patient Signature: _____ Date: _____

FACILITY NAME MUST BE FILLED IN BLANK BELOW

THPGAUTHOTH

Texas Health®

AUTHORIZATION TO VERBALLY RELEASE INFORMATION - OTHERS

Patient Name: _____

DOB: _____

MRN: _____