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Authorization to Verbally Discuss Protected Health Information

Patient Name	Date of Birth

Complete Care has my permission to discuss the information I have marked below with the following people:

1. Name:_____
   Phone:_____
   Relationship to Patient:_____

2. Name:_____
   Phone:_____
   Relationship to Patient:_____

3. Name:_____
   Phone:_____
   Relationship to Patient:_____

The following information may be verbally shared with the people listed above:
(This form does not authorize releasing copies of my records.)

Scheduling/Appointment Times and Dates
Medical information, including my symptoms, diagnosis, medications and treatment plans
Lab/Imaging/other test results
Billing and Payment Information
Other: _____

I understand that I have the right to revoke my permission at any time, and that these permissions remain in effect until the time I revoke in writing.

Signature of Patient/Authorized Representative: _____

Date:_____