

3156 State St.
Medford, OR 97504



(Ph) 541.773.9772
(Fx) 541.773.1113
www.CompleteCare.net

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: _____