Authorization for Verbal Communications

I, _____, authorize Valley Obstetrics and
(Name: Please Print) (Date of Birth)

Gynecology, their physicians, nurses, and other personnel ("health care providers") to discuss health information, in person or by telephone, with the following **family member or person directly involved in my medical care**.

Name (Please print)	**Phone Number**	**Relationship**

I AUTHORIZE THIS COMMUNICATION TO INCLUDE:

☐ All health care information
☐ Health care information in my medical record relating to the following treatment/condition:_____
☐ Health care information in my medical record for the date(s):_____
☐ Other (i.e. x-rays, bills, etc) specify date(s):_____
☐ Can schedule and reschedule appointments on my behalf

I UNDERSTAND THAT THIS AUTHORIZATION IS:

- **Limited** to verbal and telephone conversations and **does not permit** or authorize the release of any **written health information** to any of the individuals named above.
- **Limited** to the specific timeframe determined by me and that **if I do not specify a specific timeframe,** this authorization will **remain in effect for one year from signed date.**

I further understand that if, I do not want verbal discussions to be permitted between my health care provider and the individual named above I have the right to revoke this authorization, in writing, at any time. I understand that this written revocation will **not** affect any disclosures of my medical information that the person and/or organization listed on this authorization that have already made, in reliance on this authorization, before the time I revoke it.
This document has been explained to me and all of my questions have been answered satisfactorily.

_____ _____/_____/_____
(Signature of patient or legal representative) (Date)

_____
(Relationship to patient)

This authorization is NOT valid unless it is signed and dated by the patient or their representative.
This authorization will expire one year from the date signed.

Who May Sign This Authorization:

1. Generally, all patients 18 years of age or older must sign for communication of their own health information unless the following conditions apply:
    - The patient is incompetent
    - The patient is disabled an cannot sign the form

2. All persons signing for communication of health information on behalf of the patient must state their relationship to the patient and provide proof of legal authority of their capacity to act for the patient

3. Minors: Patients under the age of 18 must sign for communication of their health information in the following cases:

    - **Age 13 or older:** Alcohol, drug abuse, birth control, mental health treatment
    - **Age 14 or older**: sexually transmitted disease treatment including HIV/AIDS
    - **Any age for**: reproductive health and pregnancy related

Release of Information under this document is limited to **VERBAL** discussions only. This authorization does not authorize release of written information or **copies** of medical records to the individuals listed.
– Use the Valley OBGYN Medical Records Release Form

To revoke this authorization you must notify your health care provider by contacting **Valley OBGYN** and complete a written document revoking this authorization.