Permission for Verbal Communications

_____ _____ _____
(Patient Name) (Patient DOB) (Patient Phone Number)

I permit Ear, Nose and Throat Center of the Ozarks, their physicians, nurses, and other personnel to discuss health information, in person or by telephone, with the following family members or friends involved in my medical care: (List family members/friends, phone number, and state the person's relationship to the patient).

Name	**Phone Number**	**Relationship**
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

This authorization is limited to discussions regarding the following medical condition(s):
_____

(If no limitations are listed, discussions will be permitted regarding any medical condition for which the patient has received care.)

Release of information under this document is limited to verbal discussions with my Health Care Providers. This document does not permit release of any written health information to the individuals named above.

This authorization is limited to the following timeframe from _____ (date) to _____ (date). (If no dates are indicated, this form will remain in effect for an unlimited amount of time.)

If, at any time, I do not want verbal discussions to be permitted between my Health Care Providers and any of the individuals named above, I must notify my Health Care Provider by contacting the Ear, Nose and Throat Center of the Ozarks at 479-750-2080.

Patient's Signature: _____Date: _____

If this Release is signed by a representative on behalf of the patient, complete the following:
Representative's Name: _____
Relationship to Patient: _____