westmed medical group

Health Information Management Department
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AUTHORIZATION

To Verbally Communicate Protected Health Information

Patient Name:	Phone Number:
Patient Address: Street, City, State, Zip	
Medical Record #:	Date of Birth: MM DD YY

"I hereby authorize WESTMED Medical Group to verbally disclose my protected health information (information pertaining to my medical records and/or financial records) as indicated below."

THIS INFORMATION CAN BE COMMUNICATED TO (Relationship):

□ Spouse □ Child □ Friend □ Other _____	□ Spouse □ Child □ Friend □ Other _____
Name	Name
Street Address	Street Address
City, State, Zip	City, State, Zip
Phone	Phone

DESCRIPTION OF INFORMATION TO BE DISCLOSED:

□ Physician may communicate medical information to the above person.
□ Lab/Radiology results (Limited to verbal discussions only with my Health Care Providers)
□ WESTMED may communicate financial information regarding my treatment.
□ Other _____

For dates of treatment from _____ to _____

□ All medical/financial information. □ Information limited to _____

TO BE READ AND SIGNED BY PATIENT:

I understand the following:

a. I may revoke this authorization at any time by providing written notice to WESTMED.
b. I may not be able to revoke this authorization if WESTMED has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
c. WESTMED will not condition treatment or payment based on my signing this authorization.
d. I am signing this authorization freely and under no pressure from any individual to do so.
e. I acknowledge that I have had an opportunity to review this authorization and understand the intent and use.
f. I will receive a copy of this completed and signed authorization form.

Patient Signature		Date
Signature of Patient's Representative	Relationship	Date

OFFICE USE ONLY:
□ I.D. Verified: Type _____ Initials _____