McFarland Clinic

Patient Authorization for Verbal Communication

Please Print

Patient: _____
(First Name) (Middle Initial) (Last Name)

Date of Birth: _____ Medical Record # _____

LEAVING VOICE MESSAGES:

I give permission for detailed appointment, medical care, test results and billing information to be left on voicemails at the following telephone numbers:

Home #_____ Cell #_____Work#_____

Detailed messages will not be left on an unidentified device or with other individuals unless listed below.

COMMUNICATION WITH OTHERS:

I give permission for the following person(s) to receive detailed verbal information regarding my appointments, medical care, test results and billing:

	NAME	PHONE	RELATIONSHIP
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

AUTHORIZATION:

I understand this form of communication will be used as the standard until revoked in writing by patient. I also understand any release which was made prior to my revocation shall not constitute a breach of my rights to confidentiality. Patient may revoke this authorization by sending a signed & dated letter to: McFarland Clinic PC - Privacy Officer - PO Box 3014 - Ames, IA 50010.

_____ _____ _____
Signature of Patient *(Parent or Legal Guardian)* Relationship *(if not patient)* Date

_____
Address City State Zip Code

REGARDING MINORS:

Both parents must sign this document if both maintain legal parental rights. If 2nd parent is unable to sign, please use the comments section below to explain. When the patient reaches age eighteen (18), this authorization automatically expires.

_____ _____ _____
Signature of 2nd Parent Relationship Date

_____
Address City State Zip Code

COMMENTS:

This authorization does not provide the above named person(s) with any authority, either implied or direct, over treatment or care decisions.

Return form to: McFarland Clinic PC - Release of Information Dept, PO Box 3014, Ames, IA 50010