Premier Health

Permission For Verbal Communications

Patient Name _____ Birthdate _____ Phone _____

Patient Address _____

Street Address City State Zip

I permit Premier HealthNet, Premier Health Specialists, and Upper Valley Medical Corporation, their physicians, nurses, and other personnel ("Health Care Providers") to discuss health information, in person or by telephone, with the following family member or friend involved in my medical care (LIST ONLY ONE PERSON):

Name _____ Relationship to patient _____ Phone _____

Release of information under this document is limited to verbal discussions with my Health Care Providers.

I understand that the information a person receives may be redisclosed and no longer protected by Federal privacy regulations. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment. I understand that this authorization shall remain in effect for one year from the date of my signature below unless I specify an earlier expiration date in this space _____. **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 Practice Manager at the address and phone below. The Health Care Provider will not be liable for any communications that were permitted by this form and that were made prior to this notification.**

I also understand that the information specified above may contain information related to treatment for drug and/or alcohol abuse or for psychiatric/psychological and/or medical conditions, or HIV test results or diagnosis, I am including this type of information to be released in association with this type of authorization.

It is my desire that the information in my ____ inpatient record, ____ clinic record, ____ emergency record, ___ ambulatory testing (please mark appropriate record(s)) indicated below is to be released as a result of this authorization:

___ Face Sheet	___ Laboratory Reports	___ Therapy Reports
___ History & Physical	___ Operative Reports	___ Emergency Treatments
___ Discharge Summary	___ Pathology Reports	Other specified here:_____
___ Consultation Reports	___ Physician Progress Notes	_____
___ Radiology Reports	___ Physician Orders	_____

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 _____

Witness_____ Reason patient is unable to sign_____

INSTRUCTIONS: Please print, sign and return to:

_____ _____

Physician or Office Name **Office Phone**

_____ _____

Office Address/City/State/Zip **Office Fax**