

Family Medical Center of Hart County
117 West South Street, P. O. Box 579
Munfordville, KY 42765
270-524-7231 Fax 270-524-7415

AUTHORIZATION for VERBAL COMMUNICATION
Involvement in Patient's Care
Notification Purposes

Patient Name: _____

DOB: _____ SSN: _____

This form is to be used when a patient wishes to authorize the release of information about them, such as but not limited to, condition, diagnosis, treatment plan, and test results financial/billing status or information or death to a designated person or persons.

*******THIS AUTHORIZATION IS NOT A RELEASE FOR COPIES OF MEDICAL RECORDS*******

I authorize FMC to disclose information regarding me as described above to the following person(s):

Name of person: _____ DOB: _____

Relationship to patient: _____

____ Patient's physical location

____ Information concerning, condition, diagnosis, prognosis, treatment plan, test results

____ Financial status and/or billing information

____ I want my protected health information released to all disaster relief effort agencies, if applicable

I understand that this authorization to communicate with the above name person(s) will remain in effect unless revoked in writing by the patient or a person who has been named a guardian by the courts. Family Medical Center of Hart County reserves the right not to release any information to a designated person if in the professional opinion of the provider the release of particular information would be harmful to the patient.

Signature

Date

Print Name

If not patient, state relationship to patient

WITNESS

TITLE