



Physician Clinics & Sentara Therapy Solutions Verbal Release of Information

_____ MRN

I give permission for Sentara Health and its providers working at the below-named clinic to **verbally** share the information I have checked in the boxes below with the family members, friends or others that I have identified below as being involved in my health care and/or in the coordination of or payment for my health care.

Completion of this form is optional.

This form does not authorize the release of medical records.

Patient Name: _____

Date of Birth: _____

I authorize the following Clinic to disclose the information described below:

Clinic Name & Address: _____

Check all boxes that apply:

- Medical information, including my symptoms, diagnosis medications and treatment plan
- Behavioral Health information, including my symptoms, diagnosis, medications and treatment plan
- Substance use disorder information
- Past and future appointment dates
- Lab/test results
- Check here to include HIV results
- Billing and payment information

List up to four (4) family members, friends or others who are allowed to verbally receive information based on the boxes checked above.

1. _____
First Name/Last Name Relationship/Phone
2. _____
First Name/Last Name Relationship/Phone
3. _____
First Name/Last Name Relationship/Phone
4. _____
First Name/Last Name Relationship/Phone

I understand this authorization does not prohibit Sentara Health providers from disclosing my protected health information to other individuals who are involved in my care and/or in the coordination of or payment for care that may not be identified on this form if the disclosure is permitted by law.

I understand this authorization is valid for one year and I have the right to revoke (take back) or amend (change) my permission at any time. However, if Sentara Health has already made disclosures to the individual(s) listed in this form before my permission is taken back or changed, Sentara Health cannot get that information back.

Signature of Patient/Authorized Representative _____ Date _____

If other than the patient, state your relationship and authority to sign _____