OREGON
INTERVENTIONAL
PAIN CONSULTANTS

Permission to Verbally Discuss Protected Health Information

Patient Name: _____ Date of Birth: _____

In some cases, patients may wish to have information regarding their medical condition(s), medications, scheduled appointments, lab results, etc. discussed with individuals involved in their care such as family members, friends or caretakers. If this applies to you, please indicate below any person with whom you would like us to share protected health information regarding your care.

I give permission to Oregon Interventional Pain Consultants to verbally discuss information regarding my medical care to the following person(s):

Name	Relationship to Patient	Phone Number

I understand that I may cancel this permission at any time (by writing to Oregon Interventional Pain Consultants), but that cancelling it will not affect any information that has already been disclosed.

I understand that I do not have to sign this form, and that I should only sign it if I want Oregon Interventional Pain Consultants to share my information with someone.

This form is only for the release of verbal information and not for disclosure of medical records.

I authorize Oregon Interventional Pain Consultants to leave protected health information at the following:

- Voice Message Number: _____
- Fax Number: _____

PATIENT SIGNATURE: _____ DATE: _____

Last Review Date: 08/30/2016