HealthCare

Lexington, Kentucky

MRN: _____

Patient Name: _____

Prefers: _____

DOB: _____

DOS: _____

PERMISSION TO COMMUNICATE HEALTH INFORMATION

Note to Staff: This form does not constitute an authorization for release of written information. Only authorized personnel may release written information and then pursuant to University policies.

	YES	NO
May we leave information regarding your diagnosis, treatment and follow-up on your voicemail? (Pt must provide number _____)	☐	☐

May we discuss your diagnosis, treatment, and follow-up with the family member(s) and/or caregiver(s) listed below:

Name (Please print)	Phone

This authorization applies to this treatment area only and will remain in effect until I give a written or verbal notice to revoke it.

NOTE: Interpretive services must be offered for preferred languages other than English.

Patient Signature/Patient Representative **Date / Time**

Verbal Authorization From Patient Received By **Date / Time**

Interpreter Name or ID# ☐ **In person** ☐ **Via Cyracom**