ACTIVE CHOICE HEALTHCARE
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Authorization for Verbal Communication (both in person and on the telephone) and/or to Leave Voice Mail Messages

1. Patient Information:

Name: _____ Date of Birth: _____

2. Verbal Communication with:

			OK to leave Voicemail?
Name: SELF _____	Ph:_____	Relation: SELF _____	☐
Name: _____	Ph:_____	Relation:_____	☐
Name: _____	Ph:_____	Relation:_____	☐
Name:_____	Ph:_____	Relation:_____	☐

3. Purpose of Communication: Continued Care, unless specified:

_____

In accordance with the conditions listed above, I authorize the verbal use and/or disclosure of my medical information. No copies of medical records may be released. I understand that I have the right to revoke this authorization at any time, in writing.

I understand that I am not required to sign this release in order to receive treatment.

This authorization includes disclosure of information regarding psychiatric consults and mental illness, developmental disabilities, alcohol or drug treatment, AIDS or AIDS-related illness, sexually transmitted infection, and/or HIV test results unless I limit the disclosure to *exclude* the following: _____

_____

Signature of Patient/Representative: _____ **Date**: _____

(If signed by person other than the patient, print name and state relationship and authority to do so):

Print Name: _____ Relationship: _____

Patient is: ☐ Minor ☐ Incompetent / Incapacitated

Legal Authority: ☐ Legal Guardian ☐ Parent of Minor ☐ Health Care Agent