

## Consent for Disclosure

### Permission to Leave Phone Messages and / or Verbally Discuss Protected Health Information

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Previous/Maiden Name \_\_\_\_\_

I give permission for Myrtue Medical Center to verbally share my medical information with the following individual(s) identified below who are involved with my care or payment for my care. This permission allows verbal, in person or telephone communication including telephone messages. In addition, I authorize Myrtue Medical Center to leave messages on my telephone.

**If the below is not completed, I only authorize Myrtue Medical Center to leave messages on my telephone.**

Name		Relationship	
Phone		If minor, Mother / Legal Guardian	

Name		Relationship	
Phone		If minor, Father / Legal Guardian	

Name		Relationship	
Phone			

Name		Relationship	
Phone			

Please check each box of information which is further protected by law:

Substance Use/Abuse (drug and alcohol)       Mental Health

I understand in certain situations Myrtue Medical Center may speak to other individuals who are involved in my care or payment for my care, if permitted by law, who may not be identified on this form. I understand, any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. **This Consent for Disclosure will remain in effect for one (1) year from the date signed.** I understand I have the right to revoke my permission at any time except where Myrtue Medical Center has already made disclosures with this request.

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Patient or Authorized Representative Signature

Relationship

Date