AUTHORIZATION TO VERBALLY RELEASE MEDICAL INFORMATION

If we needed to call you about health information or schedule changes, please specify whether or not we may leave a message on the following phones:

	Leave A Message?	
Cell Phone:	__Yes __No	Phone Number: _____
Home Phone:	__Yes __No	Phone Number: _____
Alternate Phone:	__Yes __No	Phone Number: _____

May we text you regarding appointment schedule changes if we cannot reach you by phone? __Yes __No

There may be times when friends or family members, including spouses, may inquire about your healthcare, such as appointment times, prescription refills, test results, or general medical health information. This is *protected* information, and we cannot share that with anyone unless you have listed their name on this form. Please read carefully and let us know if your protected information can be released. If you prefer, you may note specifically what information can be released.

Please check one option below.

☐ I DO NOT want ANY of my information released, even to my spouse.

☐ I would like to name the following family member(s) or friend(s) as someone with whom Horizon Healthcare can share any of my information with, including psychiatric health, drug and alcohol treatment, and communicable diseases:

Name/Facility: _____Relationship: _____Phone#:_____

Name/Facility: _____Relationship: _____Phone#:_____

Name/Facility: _____Relationship: _____Phone#:_____

Name/Facility: _____Relationship: _____Phone#:_____

I understand and acknowledge by signing below that it is my responsibility to notify Horizon Healthcare when any information changes, including but not limited to phone number, ability to leave a message, and those that may verbally have my information released to them.

Signature: _____ Date: _____
PATIENT, PARENT, OR LEGAL RESPONSIBLE PARTY

Relationship to Patient: _____ Patient's Date of Birth: _____

Witness**:** _____ REV 04/2024