Family Medical Center of Hart County
117 West South Street, P. O. Box 579
Munfordville, KY 42765
270-524-7231 Fax 270-524-7415

AUTHORIZATION for VERBAL COMMUNICATION
Involvement in Patient's Care
Notification Purposes

Patient Name:_____

DOB:_____SSN: _____

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This form is to be used when a patient wishes to authorize the release of information about them, such as but not limited to, condition, diagnosis, treatment plan, and test results financial/billing status or information or death to a designated person or persons.

*******THIS AUTHORIZATION IS NOT A RELEASE FOR COPIES OF MEDICAL RECORDS*********

I authorize FMC to disclose information regarding me as described above to the following person(s):

Name of person: _____ DOB: _____

Relationship to patient: _____

____ Patient's physical location

____ Information concerning, condition, diagnosis, prognosis, treatment plan, test results

____ Financial status and/or billing information

____ I want my protected health information released to all disaster relief effort agencies, if applicable

I understand that this authorization to communicate with the above name person(s) will remain in effect unless revoked in writing by the patient or a person who has been named a guardian by the courts. Family Medical Center of Hart County reserves the right not to release any information to a designated person if in the professional opinion of the provider the release of particular information would be harmful to the patient.

_____ _____
Signature **Date**

_____
Print Name

_____
If not patient, state relationship to patient

_____
WITNESS

_____
TITLE

06/2007, 06/2012