



M.R.N.:

NAME:

D.O.B.

DATE:

VERBAL RELEASE OF INFORMATION

RiverBend Medical Group is allowed to give verbal medical information or updates about your condition to your Power of Attorney for Healthcare/Legal Representative as listed in your medical record.

If you wish others, such as relatives or friends, **who ask** about your condition, the right to be **verbally informed** about your condition when they ask, please list the names of those people on the lines below.

I am authorizing the release of **verbal medical information** regarding my treatment, care and updates on my condition to the following individuals:

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

- I understand that RiverBend Medical Group will continue to rely on the information on this form when communicating with family members or others involved in my care unless I request changes.
- I understand that I may revoke this authorization at anytime.
- I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Privacy Officer at RiverBend Medical Group. The revocation will not apply to information that has already been disclosed prior to receipt of written revocation.
- I understand that the information disclosed may include matters regarding mental health, developmental disability, genetic information, alcohol and/or substance abuse, infectious diseases including HIV, AIDS/ARC, and/or sexually transmitted disease, abortion or domestic sexual assault. **(IF YOU DO NOT WISH SUCH INFORMATION TO BE DISCLOSED, DO NOT COMPLETE OR SIGN THIS FORM)**

SIGNATURE OF PATIENT OR GUARDIAN

DATE