Permission to Verbally Discuss Protected Health Information

Patient name	Date of birth		
Patient street address	City	State	Zip
Home phone	Work phone		

I give permission to Balanced Health and Wellness to VERBALLY discuss the following medical and billing information about me *(check all boxes that apply)*. YOU MUST CHECK AT LEAST ONE.

- ☐ Scheduling/Appointment information
- ☐ Medical information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Behavioral health information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Chemical dependency information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Lab/test results
- ☐ Billing and payment information
- ☐ **I DO NOT WANT ANY INFORMATION RELEASED TO ANYONE**

Balanced Health and Wellness has my permission to discuss the above information with:

1 Name _____ Relation to patient: _____

Home phone _____ Work phone _____

2 Name _____ Relation to patient: _____

Home phone _____ Work phone _____

3 Name _____ Relation to patient: _____

Home phone _____ Work phone _____

I understand that I have the right to revoke my permission at any time except where Balanced Health and Wellness has already made disclosures in reliance upon this request. **I understand that I must notify Balanced Health and Wellness in writing if I want to revoke my permission.**

Date _____

Signature of Patient/Authorized Representative **X** _____

If authorized representative, please sign and attach copies of supporting legal documentation.

Reason patient unable to sign _____

NOTE: For copies of medical records, contact Balanced Health and Wellness.

—Information sheet on back—