PERMISSION FOR VERBAL COMMUNICATION

(HIPAA RELEASE FORM)

Patient Name | Date of Birth | Phone Number(s)

Full Address (City, State, and Zip Code)

I permit The Strittmatter Center for Wellness to discuss personal medical health information, in person and/or phone, with the following persons involved in my medical care for the following purposes:

- **To orally schedule or confirm my appointments.**
- **To discuss my care including the results of diagnostic test, diagnosis, prognosis, and treatment plans.**
- **To discuss billing and payment for medical services.**

I understand that this document applies to The Strittmatter Center for Wellness. I understand that this authorization is voluntary and that once this information is disclosed to the person(s) designated it may be re-directed by them and may no longer be protected by state or federal privacy laws.

	Name	**Relationship**	**Phone Number**
1.			
2.			
3.			

I further understand that I may revoke this authorization at any time and that this will be updated yearly by the office.

Signature of Patient or Legal Representative | Date

Print Name of Patient or Legal Representative | Relationship to Patient

Witness