WATERTOWN FAMILY PRACTICE ASSOCIATES, S.C.

PERMISSION FOR VERBAL COMMUNICATIONS

_____ _____
(Print name of patient) (Birth date)

_____ _____
(Street address) (City, state, zip code)

_____
(Telephone number)

I permit Watertown Family Practice Associates, S.C., their physicians, physician extenders, nurses, and other personnel ("Health Care Providers") to discuss health information, in person or by telephone, with the following family members or friends involved in my medical care: (List family members/friends and state the person's relationship to the patient).

This authorization is limited to discussions regarding the following medical condition(s):

_____
(If no limitations are listed, discussions will be permitted regarding any medical condition for which the patient has received care.)

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

Release of information under this document is limited to verbal discussions with my Health Care Providers. This document does not permit release of any written health information to the individuals named above.

This authorization is limited to the following timeframe from _____ (date) to _____ (date). If no dates are indicated, this form will remain in effect for an unlimited amount of time.

If, at any time, I do not want verbal discussions to be permitted between my Health Care Providers and any of the individuals named above, I must notify my Health Care Provider by contacting the Watertown Family Practice Associates, S.C. Health Information Department.

Patient's Signature: _____ Date:_____

If this release is signed by a representative on behalf of the patient, complete the following:

Representatives Name:_____

Relationship to Patient:_____

INSTRUCTIONS: Please print, sign and send to:
Watertown Family Practice Associates, S.C.-Health Information
Attention: Scanning
127 Hospital Drive
Watertown, WI 53098

Phone: (920)261-8500
Fax: (920)261-8828

Reset Form Print

04/2015