Pacific Care Medical Group
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Authorization for Verbal Communication

This authorization allows **Pacific Care Medical Group** to verbally release confidential psychiatric/therapy/mental health information, pertaining to my care, as indicated below to the person/entity listed:

_____ _____

Name **Relationship to Patient**

_____ _____

Phone Number **Alternate Phone Number (optional)**

- The undersigned agrees that they are responsible for revoking this authorization at any time by notifying Pacific Care Medical Group's Privacy Officer, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
- This authorization will *expire one year* from signature unless otherwise indicated.
  Other specific expiration date (cannot exceed 1 year from date signed): _____ (mm/dd/yyyy)
- The undersigned agrees that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing protected information.
- Purpose of Communication: Continued Care, unless specified: _____
- This authorization is for verbal communication only. **This does not authorize release of copies of medical records**. In accordance with the conditions listed above, I authorize the use and/or disclosure of my medical information. I limit the disclosure to exclude the following:_____
  _____ *(optional)*
- Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.
- The undersigned's health care and payment for health care will not be affected if they do not sign this form.
- The undersigned understands that their refusal to sign this authorization will not jeopardize their right to obtain present/future treatment for psychiatric disabilities except where disclosure is necessary for treatment.
- A photocopy of this form will be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

_____ _____ _____

Patient's Name (PRINT) **Patient's Date of Birth** **Patient's Phone Number**

_____

Patient's Address

_____ _____

Signature of Patient *or legal/personal representative* **Date**

Indicate the Relationship below:

[ ] Self **[ ]** Parent/legal guardian of a minor **[ ]** Guardian/Conservator of an incompetent patient

[ ] Minor (Ages 12 – 17) has consented to treatment and did not need parental or guardian consent

[ ] Beneficiary/personal representative of a deceased patient's estate **[ ]** Spouse and/or other person financially responsible for payment of health care claims/services (only information for purposes of processing an application for health care coverage or payment of health care services may be disclosed)

_____ _____

Witness/PCMG Staff **Date**