EXCELSIOR FAMILY MEDICINE

PH: 509-467-1100 FAX: 509-468-0173
NORTH: 9631 N Nevada, Ste 202, Spokane, WA 99218
WEST: 3754 W Indian Trail, Spokane, WA 99208

Authorization for Verbal Disclosure of Health Information

This authorization allows for verbal communication between Excelsior Family Medicine and the designated person(s) on this form. It does not allow for copies of medical records to be released.

I give permission to Excelsior Family Medicine to verbally discuss, in person or by telephone, my medical treatment and payment with the following person(s) listed below.

Please check below whether this release applies to all of your services or just the ones below.

This authorization applies to:

- ☐ All my services throughout Excelsior Wellness.
- ☐ All my Excelsior Family Medicine services.
- ☐ Only my Excelsior Family Medicine Primary Care services.

List the Name of the person(s) who you give permission to discuss your condition:

Print Individual Name & phone number	Relationship to Patient
Print Individual Name & phone number	Relationship to Patient

I agree with the terms of this Authorization:

Print Patient's Name & Date of Birth	Relationship to Patient

Expiration: This authorization will expire (choose one):

- ☐ On ___/___/_____
- ☐ Upon the expiration of the following event: _____ OR _____
- ☐ Never

Revocation: I may revoke this authorization at any time, in writing, or by updating this form with Excelsior Family Medicine. Written revocation will not affect any communication of your medication information that Excelsior has already made, in reliance on this authorization, before the time you revoke it.

No obligation to Sign: You are not under obligation to sign this form. Excelsior may not refuse to provide you treatment or other care services if you refuse to sign this form.

For Office Use:

- ☐ Patient refuses or unavailable to sign
- ☐ Patient does not want to receive a copy of this document
- ☐ Patient requested and was given a copy of this document
- ☐ No Responsible Person Available.

Staff member initials _____ Date: _____