

Patient Label

Morganton Eye Physicians, PA
Authorization for Verbal Communications

Patients often allow family members such as their spouse, parents, children, or others to call and request medical, billing, and appointment information. If you wish to have your medical, billing, or appointment information released to another person, you must complete this form. Signing this form will only give consent to the verbal release of information to the person(s) indicated below.

I authorize Morganton Eye Physicians, PA to discuss, in person or by telephone, the selected information with the person(s) listed below. I understand that the information may be re-disclosed by the person(s) listed below and that it may no longer be protected by federal or state privacy laws. Please check as applicable:

- All Medical, Appointment, Payment and Billing Information
Medical Information Only
Appointments Only
Payment and Billing Only

The selected information is to be disclosed to the persons listed below who have the indicated relationship to me/the patient.

Name

Relationship

Name

Relationship

Name

Relationship

Name

Relationship

I do not authorize Morganton Eye Physicians, PA to release any information to anyone other than myself.

Release of information under this document is limited to verbal discussions only. This document does not permit release of any written health information to the individuals named above. I understand that I may revoke this authorization at any time by notifying Morganton Eye Physicians, PA in writing. I am aware that my revocation is not effective to the extent that this authorization has already been acted upon. Authorizing this release is voluntary and I have the right to refuse to sign this release.

Signature of Patient/Personal Representative

Date