BOCACARE®
BOCA RATON REGIONAL HOSPITAL
PHYSICIAN NETWORK

Permission to Verbally
Discuss Protected Health information

I (_____, give permission to BocaCare, nurses and other personnel to **VERBALLY** discuss the following information (check all boxes that apply) :

- ☐ Scheduling/Appointment Information
- ☐ Medical Information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Behavioral health information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Substance abuse information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Lab/Test Results
  - ○ Check here to include HIV/AIDS and any other Venereal Disease Screening ordered by provider
- ☐ Billing and Payment information
- ☐ Other (describe): _____

BocaCare, its nurses and other personnel have my permission to discuss the above information with the following family, friends or other people (excluding physicians participating in my care) that I have identified below as being involved in my health care, care coordination or payment of my health care.

1) Name: _____ Relationship: _____
   Home: _____ Cell Phone: _____

2) Name: _____ Relationship: _____
   Home: _____ Cell Phone: _____

Telephone Authorization:

I hereby give permission to BocaCare, nurses and other personal to contact me in the following manner (circle one):

- ☐ Cell: _____ (authorization to leave detailed message on voicemail/call back number only)
- ☐ Home: _____ (authorization to leave detailed messages on voicemail/call back number only)

Release of information under this document is limited to verbal discussions. This form **does not permit release of any written health information or records** to the individuals named above.

I understand the expiration of this authorization is one year from today's date.
I understand that this authorization is voluntary and that BocaCare may not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.
I understand that I may receive a copy of this form after I have signed it.

I understand that I have the right to revoke my permission at any time, except where BocaCare has already made such disclosures in reliance upon this request. I understand that I must notify BocaCare in writing if I want to revoke my permission.

_____ _____
Signature of patient/Patient Representative Date/Time

_____ _____
Printed Name or Patient Representative Relationship to patient (if other than patient)

_____ _____
(Witness Signature) Date/Time