Clifton-Fine Hospital
A SAMARITAN HEALTH PARTNER

PERMISSION TO VERBALLY SHARE MEDICAL INFORMATION

Patient Name: ______________________________ Date of Birth:______________________________

I hereby give Clifton-Fine Hospital permission to verbally share specific medical information, in person or over the phone, with the individuals listed below:

Name: _________________________________
Relationship: ____________________________
Address(city/state): _______________________
Phone: _________________________________

Name: _________________________________
Relationship: ____________________________
Address(city/state): _______________________
Phone: _________________________________

Name: _________________________________
Relationship: ____________________________
Address(city/state): _______________________
Phone: _________________________________

Name: _________________________________
Relationship: ____________________________
Address(city/state): _______________________
Phone: _________________________________

The information that can be shared: (circle Y or N)

(Y / N) Appointment Date/Times (Y / N) Diagnosis (Y / N) X-ray Results (Y/ N) Lab Test / Results
(Y / N) Medications (Y / N) Care Plan
____ Other: (Specify): ____

Indicate if this additional Confidential Information can be shared:
(Y / N) Mental Health (Y / N) HIV Information (Y / N) Alcohol / Drug Information

This authorization shall remain in effect until (Please check one):

_____ (Specify expiration date or event) ___________________________
_____ When revoked in writing
_____ NO EXPIRATION DATE

Signature of Patient or Personal Representative: __________________________ Date: ____________

Printed name (If signed by personal representative): ____

If patient cannot physically sign, and has verbally granted permission, or Personal Representative has verbally granted permission, two (2) CFH employees may witness and sign below:

CFH Employee printed Name:___________________________________Title: ______________________

Signature: ____Date:_______________

CFH Employee printed Name:___________________________________Title: ______________________

Signature: ____Date:_______________

TO OBTAIN WRITTEN INFORMATION AN AUTHORIZATION TO RELEASE RECORDS MUST BE COMPLETED