HEALTHCARE CENTERS of MORRIS HOSPITAL

CONSENT FOR VERBAL RELEASE OF INFORMATION

Patient Name: _____ Date Of Birth: _____

Please list your preferred numbers	Type (please circle)	Leave Message to call the office	Leave Detailed message regarding instructions	Leave detailed message with Lab/Test results
Primary: ( ) -	Home Work Cell	YES NO	YES NO	YES NO
Secondary: ( ) -	Home Work Cell	YES NO	YES NO	YES NO

- Answering machines and voice mail must have an identifying message to confirm these are your numbers. For Example: "You have reached John"

Please list any person with whom we **MAY** share details about your healthcare.
Indicate below whether this may include appointments, messages, test results or instructions, billing information, and sensitive health information (SHI) such as mental health, developmental disabilities, AIDS/HIV or other STD treatments and/or diagnosis, Drug/alcohol abuse diagnosis, treatment and or referral and genetic testing. (Minors 12 and over have certain rights to treatment and confidentiality of sensitive information. They may exercise these rights to restrict information in specific situations).

Name	Relationship	Phone Number	May make or cancel Appointment	May Leave a message to call the office	May give normal test results or instructions	May release billing information	May release Sensitive Health Information
			YES NO	YES NO	YES NO	YES NO	YES NO
			YES NO	YES NO	YES NO	YES NO	YES NO
			YES NO	YES NO	YES NO	YES NO	YES NO

I understand that this consent is valid, until it is revoked by me, and applies to information about me obtained through Morris Hospital and Healthcare Centers. I understand that I may revoke this consent at any time by giving written notice to Morris Hospital and Healthcare Centers of my desire to do so. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to Morris Hospital and Healthcare Centers.

Signature: _____ Date: _____

Printed Name: _____

Relationship to Patient: _____