SSMHealth at Home

PERMISSION FOR VERBAL COMMUNICATIONS

_____

Name of Patient

I permit SSM Health at Home, their physicians, nurses, and other personnel ("Health Care Providers") to discuss health information, billing and insurance information, in person, by telephone, or thru secured e-mail with the following family members or friends involved in my medical care: (List family members/friends, state the person's relationship to the patient and the option of including either a contact phone number or secured e-mail address).

	Name	Relationship	Phone	Secured E-mail
1.				
2.				
3.				
4.				
5.				

Release of information under this document is limited to verbal discussions with SSM Health at Home. This document does not permit release of any written health information to the individuals named above.

If, at any time, I do not want verbal discussions to be permitted between SSM Health at Home and any of the individuals named above, I must notify SSM Health at Home and the information will be updated in my health record:

By telephone: _____

By mail at: _____

Patient's Signature: _____ Date: _____

If this Release is signed by a representative on behalf of the patient, complete the following:

Representative Name: _____

Relationship to Patient: _____