VMA
Valley Medical Associates
Adult & Pediatric Medicine

PERMISSION FOR VERBAL COMMUNICATIONS

Patient Name: DOB:

I permit Valley Medical Associates, their physicians, mid level providers, nurses, and other personnel (*collectively referred to as "Health Care Providers" in this document*) **to discuss health information, in person or by telephone, with the following family members or friends involved in my medical care:**
(List family members/friends and state the person's relationship to the patient)

Name	Phone Number	Relationship
1._____	_____	_____
2._____	_____	_____

- This authorization is limited to discussions regarding the following medical condition(s):

  _____
  *If no limitations are listed, discussions will be permitted regarding any medical condition for which the patient has received care.

- Release of information under this document is *limited* to verbal discussions.
- If, at any time, I do not want verbal discussions to be permitted between my Health Care Provider and any of the individuals named above, I must notify my Health Care Provider in writing.

Patient
Signatue:_____Date_____/_____/_____

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

Representative's Name:_____

Relationship to Patient:_____