DIAGNOSTIC CLINIC MEDICAL GROUP
Your Home for Comprehensive Care

Clinic #: _____

Date of Birth: _____

AUTHORIZATION FOR VERBAL RELEASE OF INFORMATION

Diagnostic Clinic is committed to protecting the privacy and security of your health information. With your written permission, Diagnostic Clinic staff may disclose (discuss) your health information with family members, other relatives, or other person(s) you identify below, when the health information is directly relevant to that person's involvement with your care. I understand that such identified person(s) will not have access to my written health records.

I, _____ , authorize the release of verbal health information regarding my treatment and care to the following individuals.

Name	Relationship	Contact Number(s)

This form may be revoked at any time upon my written request to the Diagnostic Clinic. If I refuse to sign this form, my information will not be released verbally except as required by law. I agree to hold the Diagnostic Clinic harmless and release them from any liability for any claims or actions, which may occur as a result of the release of information. We will not condition treatment on the completion of the form.

Signature: _____ Date: _____

Print Name: _____

If Signed by Representative, Description of Relationship to Patient and Authority: _____

Acknowledgement of Receipt of Notice of Privacy Practices

The Diagnostic Clinic Medical Group, PA reserves the right to modify the privacy practices outlined in this notice.

I have received a copy of the Diagnostic Clinic's Notice of Privacy Practices.

_____ _____
Signature of Patient Date

_____
Print Name of Patient

_____ _____
Signature of Patient Representative Date

_____ _____
Print Name of Patient Representative Relationship to Patient:

rev. 7.18.16

OFFICE USE ONLY -- SCAN THIS SIDE ONLY