BAYLOR SCOTT & WHITE HEALTH
PERMISSION FOR VERBAL COMMUNICATION

Patient Name | Date of Birth | Phone Number(s)

Full Address (City, State, and Zip Code)

I permit Baylor Scott & White Health to discuss my personal medical health information, in person and/or by telephone, with the following persons involved in my medical care for the following purposes:

- **To orally schedule or confirm my appointments;**
- **To discuss my care including the results of diagnostic tests, diagnosis, prognosis, and treatment plans that may include mental health records, psychotherapy notes, AIDS/HIV test results, substance abuse treatment records, blood bank records, and/or genetic information; or**
- **To discuss billing and payment for medical services.**

I understand that this document applies to all departments, healthcare providers and/or employees with Baylor Scott & White Health. I understand that this authorization is voluntary and that once this information is disclosed to the person(s) designated that it may be re-disclosed by them and may no longer be protected by state or federal privacy laws.

	Name	**Relationship**	**Phone Number**
1.			
2.			
3.			

I further understand that I may revoke this authorization at any time by sending a written statement of revocation to Baylor Scott & White Health – Office of Corporate Compliance, 2001 Bryan Street, Suite 2200, Dallas, Texas 75201.

This document of Permission for Verbal Communication will expire upon revocation, or at the date or event specified here _____.

This document does not permit the release of written information to these individuals. My refusal to sign this authorization will not negatively affect my health care at Baylor Scott & White Health.

Signature of Patient or Legal Representative (electronic signatures not acceptable) | Date / Time

Print Name of Patient or Legal Representative | Relationship to Patient

Representative's Authority to Act for Patient
(attach supporting documentation)