Premier Health
Premier Physician Network

PERMISSION FOR VERBAL COMMUNICATIONS

Patient's Full Name | **Last 4 Digits of Social Security Number** | **Date of Birth**

Patient's Address | **City** | **State** | **Zip Code**

I HEREBY AUTHORIZE THE FOLLOWING HEALTH CARE ENTITIES, THEIR PROVIDERS, NURSES, AND OTHER PERSONNEL TO DISCUSS MY DESIGNATED HEALTH INFORMATION, IN PERSON OR BY TELEPHONE, WITH ALL OR ANY OF THE INDIVIDUALS INVOLVED IN MY CARE AND IDENTIFIED BELOW:

Health Care Providers:

- ☐ ALL PREMIER PHYSICIAN NETWORK ENTITIES AND PROVIDERS (PPN)
- ☐ Other (specify entity or provider) _____
- ☐ Other (specify entity or provider) _____
- ☐ Other (specify entity or provider) _____

Designated Health Information:

- ☐ Facesheet
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Consultation
- ☐ Emergency Room Treatment
- ☐ Physician Orders
- ☐ Mental Health Treatment
- ☐ Laboratory Reports
- ☐ Radiological Reports
- ☐ Operative Reports
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ Prescribed Medications
- ☐ Treatment Plan
- ☐ Other (specify) - _____

Part 2 Designated Health Information:

- ☐ Drug/Alcohol Abuse Treatment

State Designated Health Information:

- ☐ Psychotherapy Treatment Notes
- ☐ HIV/AIDS Related Diagnosis and Treatment

Self/Patient — **May Leave A Voicemail**

Patient Name | **Preferred Phone Number** | **Alternate Phone Number** | ☐

Individuals Involved in My Care:

Full Name | **Relationship** | **Phone Number** | ☐

Full Name | **Relationship** | **Phone Number** | ☐

Full Name | **Relationship** | **Phone Number** | ☐

I understand that the information Individuals Involved in My Care receive may be redisclosed and no longer protected by federal or state privacy regulations. I also understand that my Designated Health Information may contain information related to treatment for drug and/or alcohol abuse treatment, psychotherapy treatment, or HIV and/or AIDS related diagnosis and treatment. If applicable, by checking those respective boxes above, I acknowledge and expressly permit the inclusion of such information in verbal communications permitted by this authorization. I understand that this authorization is voluntary and that I may refuse to sign it. My refusal to sign will not affect my ability to obtain treatment. **If, at any time, I do not want my Health Care Providers to have verbal discussions with myself or any of the Individuals Involved in My Care, I must notify my Health Care Provider in writing. No Health Care Provider will be liable for communications that were permitted by this authorization and made prior to its revocation.**

I understand that this authorization expires two years from the date it is signed unless I specify a different date or time period in this space _____. I am aware that this authorization may be copied and said copy will be considered valid.

Patient/Legal Representative Signature | **Date**

If the above signature is not that of the patient, explanation must be provided below and documentary evidence of appropriate designation is required to accompany this authorization _____