FIRST CARE MEDICAL CENTER

Please Print Name: ____ Date of Birth____________

- **Acknowledgement of Receipt of Notice**

By signing below you are acknowledging that you have received a copy the First Care Medical Center Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act of 1996.

- **Permission for Verbal Disclosure**

If you would like to give First Care Medical Center staff permission to discuss your care with someone please indicate below.

I, the undersigned, authorize the First Care Medical Center to verbally disclose my Protected Heath Information to the following individual(s) or entities. I understand that this permission only applies to **verbal / spoken** communication to include but not limited to: discussion of my treatment plans, medications, test results, and upcoming procedures. I further understand that disclosure of copies of my medical record, or other written forms of my protected health information, will require my written authorization for each episode of release. This permission will become a permanent part of my medical record.

Name: ____ Ph#__________________________

Relationship____

Name: ____ Ph#__________________________

Relationship____

The individual / entity named above may receive oral disclosures about:

□ All protected health information without restriction

□ Other (specify) ____

I understand that while verbal revocations will be accepted a written revocation will be necessary for documentation purposes. Other that revocation, any changes requested will require written notification to the First Care Medical Center. I also understand that any release made prior to my revocation which was in compliance with this authorization shall not constitute a breach of my right to confidentiality.

Patient / Legal Representative Signature:

____Date:_____________________________

Relationship if other that patient: ____