St.Vincent's MultiSpecialty Group

Authorization for Verbal Disclosure

Patient Name:_____ Date of Birth:_____

In order to ensure that we communicate with you and work with you to coordinate your care, please complete the following questions.

May we contact you by:

Home Phone: ( )_____
Work Phone: ( )_____
Cell Phone: ( )_____

May we leave you a message on your answering machine?
( ) at home ( ) at work ( ) on your cell phone

May a message be left with another adult person at the above phone numbers?
( ) at home ( ) at work ( ) on your cell phone

May we contact you by mail at your home address? ( )yes ( )no
If no, please provide us with alternative mailing address:

_____
_____

Do you authorize us to speak with any other individuals regarding the coordination of your care such as making and canceling appointments, medication questions/concerns, lab results or in the case of an emergency? If so, please indicate below.

Name: _____ Phone:( )_____
Relationship:_____

Name: _____ Phone:( )_____
Relationship:_____

Name: _____ Phone:( )_____
Relationship:_____

This authorization is valid for _____ months or until the following date:_____

_____ _____
Patient Signature Date

You have the right to discontinue this verbal authorization/coordinator of care at any time. To do so, please contact our office.