721 Snelling Ave S
St. Paul, MN 55116
Fax: 651-690-5274
Phone: 651-690-1311

RELEASE OF VERBAL INFORMATION

This form is optional
Providing the information below can help to facilitate communication for your care.

☐ I give permission to Parkway Clinic **to leave a voicemail message at my phone number** on file.

☐ I give permission to Parkway Clinic **to verbally discuss information about me with:**

Name: _____ Relationship: _____

Primary phone number: _____ ☐ Mobile ☐ Home ☐ Work

Secondary phone: _____ ☐ Mobile ☐ Home ☐ Work

Information can be shared regarding:
(Check all that apply)

☐ **Appointments/Scheduling Information**
☐ **Medical Information, including my symptoms, diagnosis, medications, and treatment plans**
☐ **Billing and payment information**
☐ **Other (describe): _____**

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand I have the right to refuse to sign this authorization and that my care is not dependent on my signature.
This authorization shall be in effect until revoked in writing by the patient.

Signature of Patient/Authorized Representative: _____
Relationship to Patient: ☐ Self
☐ Other: _____ **Date: _____**

(Please complete both sides)

OFFICE USE ONLY

Entered By: _____ Chart # _____

OPTIONAL FORM