Consent for Verbal Communication

The HIPAA Privacy Regulation allows AdventHealth to verbally disclose a patient's health information to a family member, friend, or other persons if the patient agrees, or when given the opportunity, does not object.

Please list below any individuals you consent to AdventHealth verbally disclosing certain components of your health information. If you wish to obtain a copy of your medical records, please contact our HIM department.

You are not obligated to list anyone below. This form is simply to clearly designate who may be involved in your healthcare. Please specify name(s) and relationship(s) (for example, spouse, significant other, adult children, siblings, etc.).

1. Name _____

   Relationship _____

2. Name _____

   Relationship _____

3. Name _____

   Relationship _____

AdventHealth may release the following information to the individuals listed above (**please check all that apply):**

- ☐ Discuss my most recent test results;
- ☐ Leave a detailed message on my answering machine or voicemail;
- ☐ Verify the date and time of my appointments;
- ☐ Discuss information regarding my bill or make a payment on my behalf;
- ☐ Other: _____

I understand that I may revoke this consent at any time by notifying AdventHealth in writing, but if I do, it will not have any effect on any actions AdventHealth took before it received the revocation. I understand this consent will expire in one year from the date the consent is signed.

Signature: _____ Date: _____