Permission for Verbal Communication of Health Information

Patient Information (please print)			
Patient Name			Date of birth
Shipping address	City	State	ZIP
Primary Phone	Secondary Phone		

Section I: Permission for Verbal Communications

I give permission for **East Alabama Apothecary Specialty Pharmacy** to VERBALLY share the information I have checked below with the family, friends, or others that I have identified below as being involved in my health care, care coordination or payment of my health care. (*check all boxes that apply)*
This form does not authorize releasing copies of my medical records.

☐ Scheduling/Appointment information
☐ Medical information, including my symptoms, diagnosis, medications, and treatment plan
☐ Behavioral health information, including my symptoms, diagnosis, medications, and treatment plan
 ☐ Substance abuse disorder
 ☐ Developmental disability
☐ Billing and payment information
☐ Other (describe): ____

East Alabama Apothecary Specialty Pharmacy has my permission to discuss the above information with the following family, friends, and others. This information is directly relevant to their involvement in my health care (or payment for that care).

1. Name: ____

 Phone: ______________________ Relationship to patient: ______________

2. Name: ____

 Phone: ______________________ Relationship to patient: ______________

3. Name: ____

 Phone: ______________________ Relationship to patient: ______________

4. Name: ____

 Phone: ______________________ Relationship to patient: ______________

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Section II: Permission to Leave Voice Mail Messages

I allow voice messages to be left at the following phone number(s):

Primary: ______________________________________ ☐ Mobile ☐ Home ☐ Work

Secondary: ____________________________________ ☐ Mobile ☐ Home ☐ Work

Tertiary: ______________________________________ ☐ Mobile ☐ Home ☐ Work

Medical conditions excluded from voice mail messages (if any): __________________________________

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I understand that in certain situations, East Alabama Apothecary Specialty Pharmacy may speak to other individuals who are involved in my care or payment of that care, if permitted by law, that may not be identified on this form.

I understand that I have the right to revoke my permission at any time except where East Alabama Apothecary Specialty Pharmacy has already made disclosures in reliance upon this request. **I understand this permission remains in effect until the time I revoke it in writing.**

____

Patient/Representative's name and relationship to patient if other than self (PLEASE PRINT)

____ ________________________________

Patient/Representative's signature **Date**