**General Disclosure – Physician’s Clinic**

I give permission to my healthcare provider/nurse at MRHC to verbally disclose or discuss information related to my medical care with the following individual(s) identified below. This permission may be given verbally, in person or via telephone. I understand that texting is not a secure method and will not be used to communicate with my healthcare provider. The purpose of this disclosure is to allow family/friend involvement in my healthcare process and I understand that this form is not considered a legal binding form that will hold up in a court of law.

I understand that I may revoke this permission at any time by notifying Manning Regional Healthcare Center in writing or completing the below request to revoke someone’s permission. However, if I do elect to revoke someone’s permission, it will not have any effect on the actions that individual took before they received the revocation or hold Manning Regional Healthcare Center liable for medical information released prior to the revoked date. Unless otherwise revoked, this consent will expire two years from the date signed.

I understand that the person who receives the information listed below is not another healthcare provider or an entity that must follow the federal privacy standard. The health information disclosed as a result of this permission may no longer be protected by the federal privacy standards, and my health information may be re-disclosed without obtaining my authorization. I also understand that if physical records are requested, I am responsible for requesting and completing a Release of Information and records will not be released unless I do this.

**AUTHORIZING PERMISSION:**

1. AUTHORIZED NAME (please print clearly)

RELATIONSHIP TO PATIENT PHONE#

1. AUTHORIZED NAME (please print clearly)

RELATIONSHIP TO PATIENT PHONE#

1. AUTHORIZED NAME (please print clearly)

RELATIONSHIP TO PATIENT PHONE#

**REVOKING PERMISSION:**

1. AUTHORIZED NAME (please print clearly)

RELATIONSHIP TO PATIENT PHONE#

1. AUTHORIZED NAME (please print clearly)

RELATIONSHIP TO PATIENT PHONE#

PATIENT NAME (printed) PATIENT DATE OF BIRTH

PATIENT/GUARDIAN SIGNATURE DATE

I have reviewed this form and do not wish to give permission to anyone.

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FOR OFFICE USE ONLY:

WITNESS MEDICAL RECORD NUMBER