DeLand Foot&Leg CENTER
Excellence in care as you walk through life

Permission to Verbally Discuss Protected Health Information

Patient Name: _____ Date of Birth: _____

Approved voicemail/text message number to leave information: (_____)_____

I give permission to DeLand Foot and Leg Center (DFALC) to **VERBALLY** discuss the following medical and billing information about me **(check all boxes that apply)**:

- ☐ Scheduling/appointment information
- ☐ Medical information, including my symptoms, diagnosis, medications, and treatment plan.
- ☐ Behavioral/Clinical Dependency health information, including my symptoms, diagnosis, medications, treatment plan
- ☐ Lab/test results
- ☐ Billing and payment information
- ☐ Other:_____

☐ DFALC has my permission to discuss the above information with the below non-medical persons:

Name	Phone	Relationship to Patient

I understand that I may cancel this permission at any time (by writing to DFALC Health Information), but that cancelling it will not affect any information that has already been released. I understand that I do not have to sign this form, and that I should only sign it if I want my medical provider or my clinic to share my information with someone.

☐ I decline permission to verbally discuss medical information with someone else

_____ _____ _____
Signature of patient/guardian* Date Relationship to patient

_____ _____ _____
Witness if patient is unable to sign* Date Reason patient is unable to sign

*If authorized representative, please sign and attach copies of supporting legal documentation.