Trinity Health Of New England | Medical Group

M.R.N:

NAME:

D.O.B.

DATE:

VERBAL RELEASE OF INFORMATION

Trinity Health Of New England Medical Group is allowed to give verbal information or updates about your condition to your Power of Attorney or Healthcare/Legal Representative as listed in your medical record.

If you wish others, such as relatives or friends, **who ask** about your condition, the right to be **verbally informed** about your condition when they ask, please list the names of those people on the lines below.

I am authorizing the release of **verbal medical information** regarding my treatment, care and updates on my condition to the following individuals:

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

- I understand that Trinity Health Of New England Medical Group will continue to rely on the information on this form when communicating with family members or others involved in my care unless I request changes.
- I understand that I may revoke this authorization anytime.
- I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department at Trinity Health Of New England Medical Group. The revocation will not apply to information that has already been disclosed prior to receipt of written revocation.
- I understand that the information disclosed may include matters regarding mental health, developmental disability, genetic information, alcohol and/or substance abuse, infectious diseases including HIV, AIDS/ARC, and/or sexually transmitted disease, abortion or domestic sexual assault. **(IF YOU DO NOT WISH SUCH INFORMATION TO BE DISCLOSED, DO NOT COMPLETE OR SIGN THIS FORM)**

______________________________ ______________________________

SIGNATURE OF PATIENT OR GUARDIAN **DATE**