

Permission to release verbal Health Care Information

With the exceptions the law has created, you have the right to decide what verbal information the Neighborhood Doctor can release. Please take the time to read this form carefully to properly choose the option which best suits your needs.

I understand there are times when the law allows The Neighborhood Doctor to release information regardless of whether or not I give my consent. For example the Neighborhood Doctor may release information to doctors, nurses and others who provide me with health care or are prospective health care providers; to government agencies as authorized by law; to insurance companies or others who are responsible for paying my medical bills; or to a court of law that issues a subpoena or court order. I understand this information may be released either orally or in document forms.

I understand that certain "Directory Information" may be released to all who asked about me by name unless I specifically request to be a "No Information" patient as stated below. I further understand that my name, location in the hospital, one word statement regarding my general condition, and my religious affiliation may be disclosed to members of the clergy, unless I specifically request to be a "No Religious Information" patient as described below including my location in the hospital and one word statement regarding my general condition.

- STANDARD DISCLOSURE- I authorize The Neighborhood Doctor and medical members to discuss my medical history, diagnosis, treatment and prognosis with those listed below. I understand this may include information regarding testing, examination and treatment for HIV, AIDS related illness, mental health and drug, alcohol or chemical abuse.

- SPOUSE _____
- CHILDREN _____
- PARENT _____
- OTHER _____

- NO INFORMATION-I do not authorize release of any information regarding my office visit or general condition. I choose to be a "NO INFORMATION" patient and I realize that mail, telephone calls and visitors will be refused on my behalf. (T.N.D. staff will not be able to acknowledge nor deny my absence or presence.)

I understand that T.N.D. has the right to change its Notice of Privacy Practices from time to time and that I may contact T.N.D. at any time to obtain a current copy of the Notice of Privacy Practices.

Patients Name (Print) _____

Signature of Patient/Guardian _____

Date _____