Verbal Disclosure Authorization

_____ _____
Patient name Medical Record Number

_____ _____
Date of Birth Social Security Number

Your privacy and confidentiality are important to us. Community Care of West Virginia does not verbally release any information regarding medical care or test results to anyone other than the patient, unless otherwise authorized. Please indicate below the name and relationship to you of the person (such as your spouse, mother, sister, etc.) to whom we may release such information if necessary. Otherwise, we will refuse any calls requesting this information. You may revoke this authorization in writing at any time.

☐ NO – I do not wish to authorize verbal disclosure to any individual at this time.

☐ YES – I authorize you to release verbally my name and date of birth to West Virginia Wesleyan College regarding my emergency transport.

☐ YES – I authorize you to release verbally any information regarding my medical care or test results to the following individuals:

_____ _____ _____
Person Authorized to Receive Information Relationship to Patient Date

_____ _____ _____
Person Authorized to Receive Information Relationship to Patient Date

The parties agree that this agreement may be electronically signed. The parties agree that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

_____ _____
_ Patient/Guardian Signature Date