OHC
SPECIALISTS IN CANCER AND BLOOD DISORDERS

PERMISSION FOR VERBAL COMMUNICATIONS

OHC requires written authorization to discuss your care with family, friends or others.

_____ _____
Patient's Name Patient's Date of Birth

I permit OHC, their doctors, nurses, and other personnel ("Health Care Providers") to discuss health information, in person or by telephone, with the following family members or friends involved in my medical care or payment of my care. List family members/friends and state the person's relationship to the patient.

Name **Phone Number** **Relationship**

1._____
2._____
3._____

_____ **DO NOT PROVIDE** health information to anyone but me.

This authorization is limited to discussions regarding the following medical condition(s):
_____

If no limitations are listed, discussions will be permitted regarding any medical condition for which the patient has received care. **If no dates are indicated, this form will remain in effect for an unlimited amount of time.**
This authorization is limited to the following time frame from:
_____/_____/_____to _____/_____/_____
(month/day/year) (month/day/year)

Release of information under this document is limited to verbal discussions with my Health Care Providers. This document does not permit release of any written health information to the individuals named above.

If, at any time, I do not want verbal discussions to be permitted between my Health Care Providers and any of the individuals named above, I must notify my Health Care Provider by contacting 513-751-2273.

How do you wish to be contacted for appointments and test results?
□ Home/cell number_____ □ Work number _____

May OHC leave Protected Health Information on your voicemail?
□ Yes □ No □ Leave a call back number only □ Do not leave message

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices.

_____ _____
Patient's Signature Date

If this authorization is signed by a patient's personal representative on behalf of the patient, please complete the following:

_____ _____
Name of Personal Representative Relationship to Patient

_____ _____
Witness Date

Revised 1/2/2020