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

Upstate Family Health Center, Inc.

Authorization for Verbal Disclosure of Information

This will remain in effect until notified differently by patient. The patient is responsible to notify the provider if they wish to revoke this form or make a revision of any information contained within this form.

Patient Last Name	Patient First Name	Date of Birth

Upstate Family Health Center, Inc. may discuss your protected health information with the following people:

Name	Relationship/Phone #	Any Exclusive/Comments
	(_____) _____ - _____ ❑ Parent ❑ Guardian ❑ Other _____	
	(_____) _____ - _____ ❑ Parent ❑ Guardian ❑ Other _____	
	(_____) _____ - _____ ❑ Parent ❑ Guardian ❑ Other _____	

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Signature of Witness	Date
Print Name of Witness	

Note: This discussion form is not meant to replace or be used instead of SMH/HH 48 Authorization for release of Medical Information Protected info discussion permission.