2306 SE Cesar E Chavez Blvd, Portland, OR 97214
(503) 239-8430 Fax (833) 989-2221

VERBAL RELEASE CONSENT FORM

I understand that Portland Hand Clinic maintains records of my medical and billing information as part of my healthcare. Under the requirements of HIPAA, this information is not be given to any other person without my permission.

By signing this consent, I authorize Portland Hand Clinic to verbally release information as designated below, to the following individuals for the purpose of assisting with my health care and/or finances unless otherwise noted. This verbal release form does not include hard copies and/or electronic copies of medical records.

Name	Relationship	Phone Number
☐ *All Medical Records (includes billing and appointment)*	☐ *Billing information only*	☐ *Appointment information only*

Name	Relationship	Phone Number
☐ *All Medical Records (includes billing and appointment)*	☐ *Billing information only*	☐ *Appointment information only*

Name	Relationship	Phone Number
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☐ **I <u>DECLINE</u> to have my medical and/or billing information discussed with family or friends.**

This authorization will expire at the end of the calendar year in which it was signed. I understand I have the right to revoke this authorization by written request at any time.

_____

Printed Name of the Patient

_____ _____

Signature of the Patient or Responsible Party Date