



## VERIFICATION FOR TELEPHONIC and/or VERBAL COMMUNICATIONS

It is the intent of SSM Health Medical Group and our staff to provide you exceptional care. Our physician organization strives to keep your health information confidential and protected while sharing one common electronic health record. Family, friends and others involved in your care may call one or more of our provider's office(s) to inquire about your health information. To maintain confidentiality, it is best to designate the individual(s) you grant SSM Health Medical Group and/or their staff permission to share your health information with, including but not limited to lab results, x-ray/imaging results, or other information pertaining to your care.

I give my permission to SSM Health Medical Group, its group providers and/or staff to discuss my health conditions such as lab results, test results, or other information pertaining to my health care, with the following designated persons on the list below. I understand this could result in unintended disclosure of health information.

Check all that apply:

\_\_\_\_\_ Spouse Name: \_\_\_\_\_

\_\_\_\_\_ Child Name: \_\_\_\_\_

\_\_\_\_\_ Child Name: \_\_\_\_\_

\_\_\_\_\_ Child Name: \_\_\_\_\_

\_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_ Other: \_\_\_\_\_

My signature indicates that I have read the above and grant the request. I understand that if I do not sign, or list any person, the information will not be given to anyone but me. I also understand that I am able to revoke this authorization at any time and the request must be in writing. I further understand this verification is inclusive to the SSM Health Medical Group and staff members. I understand that it is my responsibility to provide written notice of changes to the list stated above.

Patient Name \_\_\_\_\_

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_