



# AUTHORIZATION TO RELEASE HEALTH INFORMATION ORALLY

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient's SSN: \_\_\_\_\_ Previous Name: \_\_\_\_\_

Olympic Sports and Spine Rehabilitation has a legal obligation to keep your personal health care information confidential. For convenience, some patients wish to allow relatives, or others access to test results or other orally transmitted health care information. If you wish to allow anyone to receive such verbal information, please list his or her name and relationship to you in the space provided. Copies your chart or other written information are not covered by this authorization. This authorization will remain in effect until revoked in writing.

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

\_\_\_\_\_  
Date

The following people listed are authorized to orally receive health care information regarding the patient named above.

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

\_\_\_\_\_  
OSSR Representative/Witness

\_\_\_\_\_  
Date