



Tacoma (253) 572-7320
 Puyallup (253) 841-4347
 Lakewood (253) 588-7778
 Gig Harbor (253) 851-0404

Authorization to Release Health Care Information Orally

Patient's Name _____ Date of Birth _____

Previous Name _____

We have 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 spaces provided. Copies of 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

Name

Relationship

This form will be retained in your medical record.