FAMILY CARE

ASSOCIATES, PC

1855 Halcyon Blvd.
Montgomery, AL 36117
334-530-6387

PERMISSION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: ____/____/____ Account No: _____

Patient Address: _____
Street Apt No City State Zip

Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____

I give permission to Family Care Associates, PC to **VERBALLY** discuss the following medical and billing information about me (check all that apply):

- ☐ Appointment information.
- ☐ Medical information including my symptoms, diagnosis, medications and treatment plan.
- ☐ Behavioral health information including my symptoms, diagnosis, medications and treatment plan.
- ☐ Chemical dependency information including my symptoms, diagnosis, medications and treatment plan.
- ☐ Lab/test results.
- ☐ Billing and payment information.
- ☐ Other: _____

Family Care Associates PC has my permission to discuss the above information with:

Name: _____ Relationship: _____

Address: _____
Street Apt No City State Zip

Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____

Name: _____ Relationship: _____

Address: _____
Street Apt No City State Zip

Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____

Name: _____ Relationship: _____

Address: _____
Street Apt No City State Zip

Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____

I understand that I have the right to revoke my permission at any time except where FCA has already made disclosures in reliance upon this request. I understand I must notify FCA in writing if I revoke my permission.

_____ _____
Signature of Patient/Authorized Representative Date

If authorized representative please attach copies of supporting legal documentation.

Reason patient is unable to sign: _____

_____ _____
Signature of Family Care Associates, PC Representative Date