Lincoln Orthopaedic Center
Dedicated Surgical Expertise

PERMISSION FOR VERBAL COMMUNICATIONS

Patient Name: _____ Date of Birth: _____

Medical Record No.: _____

I hereby expressly authorize Lincoln Orthopaedic Center to disclose or discuss my health and billing information, in person or by telephone, with the following individuals:

Name	**Phone Number**	**Relationship**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

The release of information under this Permission is limited to verbal communications between my Health Care Providers and the family members, other relatives, friends, and other persons identified above for the purpose of conveying information directly relevant to such person's involvement with my health care or payment related to my health care, as well as my location, general condition, and other limited information that, in the professional judgment of my Health Care Providers, is in my best interests.

<u>This document does not authorize the release of paper or electronic medical records.</u>

This Permission expires on _____. If no date is indicated, this Permission will remain in effect for twelve (12) months from the date of my signature, below.

Patient Signature: _____ Date: _____

Patient Name: _____