Authorization for Verbal Release of Information

Patient Name: _____ DOB: _____

Account #: _____ SSN: _____

Information to be released/discussed:

- ☐ Medical Information
- ☐ Billing Information
- ☐ Diagnosis/Treatment Plans
- ☐ Prescriptions/Refills
- ☐ Appointment Information
- ☐ All Information/Records

- ☐ Specific Date(s) of Service: _____
- ☐ All Dates of Service

- ☐ Can make changes
- ☐ Cannot make changes

To be released to whom:

Name: _____ Phone #: _____

Relation to Patient: _____ Address: _____

DOB: _____ _____

In accordance with HIPAA LAW, I, the above-listed patient, hereby authorize the staff and physicians at Katherine E Johnson MD PC, aka Mountain View Eye Center and Mountain View Optical Shoppe, to release the information in the form of verbal discussion with the individual named for the specified dates of service or until this authorization expires or is revoked. I understand that in order for the above-named individual to acquire any written documents regarding my health or my account, I will need to fill out a separate release of information form for specified dates of service. I acknowledge by my signature that I understand that although I am not required to release my information, I am giving my consent to do so. This authorization expires in three years or on _____, whichever is sooner. I understand that I may revoke this authorization in writing at any time before it expires, except for that information which has already been released with consent and prior to my revocation.

_____ _____

Patient Signature Date