# RELEASE OF VERBAL INFORMATION

TRINITY HEALTH

I, _____, _____ give my consent to allow Trinity
(patient name) (date of birth)
Health to release verbal information regarding my medical condition to the following people or facilities.

OR

I, _____, representing _____, _____
(patient designee) (patient name) (date of birth)
give my consent to allow Trinity Health to release verbal information regarding his/her medical condition to the following people or facilities.

My relationship to the patient is that of *(please circle one)*: Parent of Minor Child, Legal Guardian, (paperwork required)
Power of Attorney or Other_____.
(paperwork required) (other relationship)

1._____
Home Phone #:_____
Cell Phone #:_____

2._____
Home Phone #:_____
Cell Phone #:_____

3._____
Home Phone #:_____
Cell Phone #:_____

4._____
Home Phone #:_____
Cell Phone #:_____

5._____
Home Phone #:_____
Cell Phone #:_____

6._____
Home Phone #:_____
Cell Phone #:_____

7._____
Home Phone #:_____
Cell Phone #:_____

8._____
Home Phone #:_____
Cell Phone #:_____

I understand that this consent form authorizes release of verbal information and is valid for a **maximum** of one (1) year from the signature date below unless a prior alternate date is completed. I have the right to revoke this consent or change the list of people authorized by this consent form at any time with written notification to Trinity Health.

_____ _____ _____
Signature Date Time

_____
Alternate Expiration Date (prior to signature date)

_____ _____ _____
Representative Date Time

LEG13



*PATIENT LABEL*