PERMISSION FOR VERBAL COMMUNICATIONS

(To be used only by patients 19 years of age and older)

_____ _____

(Print name of patient) (Birth date)

_____ _____

(Street address) (City, state, zip code)

_____

(Phone number)

I permit Lincoln Pediatric Group, their physicians, nurses and other personnel ("Health Care Providers") to discuss my medical care and information, in person or by telephone, with the persons listed below:

	Name	**Phone Number**	**Relationship**
1.	_____	_____	_____
2.	_____	_____	_____

All of the information about my care and/or listed in my medical record may be discussed with the person(s) listed above EXCEPT the following:

_____

Release of information under this document is limited to verbal discussions with my Health Care Providers. <u>This document does not authorize release of paper or electronic medical records</u>.

This authorization expires on the following date: _____. If no date is indicated, this form will remain in effect until revoked.

Patient's Signature: _____ Date: _____

(Patient must sign if 19 years of age or older)

Sign and return to: Lincoln Pediatric Group
4501 S 70th St. #110
Lincoln, NE 68516
Phone: (402) 489-3834
Fax: (402) 489-5049