

Patient Name: _____

Date of Birth (DOB): _____

Medical Record Number (MRN): _____

Consent for Verbal Release of Information

Please indicate the patient's preferred phone number(s) and whether Quincy Medical Group (QMG) associates can leave detailed messages with that number. *Anyone listed here will be authorized to receive the patient's Protected Health Information (PHI) over the phone, verbally.*

Patient Phone Number(s)	Name	Relationship	Type	Leave detailed messages, including test results?
*Primary:		☐ Self ☐ Spouse ☐ Parent ☐ Other	☐ Home ☐ Work ☐ Cell	☐ Yes ☐ No
Secondary:		☐ Self ☐ Spouse ☐ Parent ☐ Other	☐ Home ☐ Work ☐ Cell	☐ Yes ☐ No

For minor patients, please indicate the name and preferred number for each parent and/or legal guardian:

Phone Number	Name	Relationship	Type	Leave detailed messages, including test results?
		☐ Mother ☐ Father ☐ Other	☐ Home ☐ Work ☐ Cell	☐ Yes ☐ No
		☐ Mother ☐ Father ☐ Other	☐ Home ☐ Work ☐ Cell	☐ Yes ☐ No

Please list any person(s) with whom QMG may share verbal details about the patient's care, including billing information. Indicate whether **Sensitive Health Information ("SHI")** (e.g., mental health, genetic testing, substance use, pregnancy, physical/sexual abuse, and sexually transmitted diseases/infections) may be included or not. **Minors aged 12 to 17 must sign below to authorize the release of SHI to their parent(s) and/or legal guardian(s).**

Name	Relationship	Share SHI?
		☐ Yes ☐ No
		☐ Yes ☐ No

Signature of Minor Patient

Date

I understand that this consent applies to information obtained through any and all QMG locations. I also understand this is not consent for treatment and is **valid until revoked by me**. I understand that I will not be able to revoke this consent in cases where it has already been relied upon to disclose my health information. I understand that QMG may ask to update this form from time to time.

Signature of Patient or Personal Representative

Date

Relation to Patient: _____