Complete Rural
Medicine

515 2nd Street, Friend, NE 68359
3900 S 6th Street, Suite 1, Lincoln, NE 68502
❖PH: 308-646-2471 ❖ Fax: 949-404-6679

Release of Verbal Medical Information

Patient Name: _____ DOB: _____

Complete Rural Medicine, LLC restricts the release of your protected health information (PHI) to that which is permitted under patient confidentiality laws. According to HIPAA regulations, your PHI can only be released for reasons relating to your treatment needs, payment/insurance reasons, and as otherwise specified in HIPAA regulations. Before any of your PHI can be given verbally to anyone, including family members, you will need to specify who you authorize to receive this information. Please list all persons who you authorize to receive this information.

I. Permission to Verbally Discuss PHI with Family Members or Caregivers

I hereby authorize medical providers and personnel of Complete Rural Medicine, LLC permission to discuss my protected health information with the following:

Full Name _____ Phone Number _____ Relationship _____
Full Name _____ Phone Number _____ Relationship _____

**Use additional forms if more space is needed. Additional form must be filled out and signed.*

II. Declination of Permission to Discuss PHI

____ I decline the option of listing anyone receiving my information. Please do not discuss my PHI with anyone, including inquiring family members.

III. Permission to Leave a Detailed Message

____ I hereby authorize Complete Rural Medicine, LLC to leave a detailed message at the following phone number: _____ or email address: _____

Signature of Patient or legal personal representative: _____ Date _____

**Document required if other than patient*

_____ _____
Second Witness for a Phone Consent Witness to Signature

Form is valid for length of stay if admitted to hospital or skilled status.
Form is valid for 1 year if pertaining to Complete Rural Medicine, LLC PHI.