



Robert E Graser DPM., PA



Permission to Verbally Disclose Protected Health Information

***Note: Completion of this form is optional. To be valid, this form must be filled out COMPLETELY, including the type of information you are granting us permission to share.**

Name: _____ DOB ____ / ____ / ____ Date: ____ / ____ / ____

I give permission to Graser/Medina Podiatry & Bunion Surgery Institute to **VERBALLY** discuss the following medical and billing information about me (check all boxes that apply):

- Scheduling/Cancelling/ appointment information
- Medical information, including my symptoms, diagnosis, medications, and treatment plan.
- Lab/test results
- Billing and payment information
- Other: _____

To the following Entities:

Name	Phone	Relationship to Patient

I understand that I may cancel this permission at any time (In writing), but that cancelling it will not affect any information that has already been released.

I understand that I do not have to sign this form, and that I should only sign it if I want my medical provider or my clinic to share my information with someone.

This authorization expires:

- When I cancel it in writing OR _____ (specify date)
If no expiration date is specified, this authorization will remain in effect until our office receives written notice to cancel it.
- I decline permission to verbally discuss medical information with anyone.

Patient Signature

PT ID (office use)