USC Engemann Student Health Center

Place Patient Label Here

Verbal Communication with Healthcare Provider

↑Patient Legal Name (Last, First)	Preferred Name	USC ID #
↑Date of Birth (MM/DD/YY):	Mobile Phone: *(XXX) XXX-XXXX*	E-Mail

Purpose:

I authorize my Engemann Healthcare Provider to discuss my healthcare with another individual.

Authorization:

Release of information under this document is limited to verbal discussions between my Engemann Healthcare Provider and the individual named below. This document does not permit release of any written health information.

I authorize my Engemann Healthcare Provider to discuss my healthcare with:

_____

↑ Name (Last, First) | Relationship | Phone (XXX) XXX-XXXX

I authorize my Engemann Healthcare Provider to discuss only health information related to:

Date(s) of Service/Treatment: *From (start date)*_____ To (end date)_____
(MM/DD/YY) (MM/DD/YY)

Note: End date not to exceed 30 days from start date.

And/Or Follow up visits related to condition: _____

Note: *It is not permissible to authorize release of information created after the consent is signed unless it is specifically tied to the condition, treatment or date of service indicated above. Prospective authorizations (i.e., authorizations requested for future visits/health information) are prohibited because it is not possible for individuals to make informed decisions about visits that have not yet occurred.*

This Authorization will automatically expire 30 days after my signature date below, unless an earlier date is indicated here: (MM/DD/YY):_____

Patient Signature:_____ Today's Date: _____
(MM/DD/YY)

If signed by representative of patient, please state relationship:_____

Witness:_____ Today's Date:_____ ☐ ID
(MM/DD/YY)

Office Use Only Requested By:	Date:	Processed By:	Date:

1031 W. 34th Street, HIM Suite LL106, Los Angeles, California 90089 • (213) 740-0206 • FAX (213) 740-4961