Monarch Family Medicine, LLC
17 Market Street
Lyme, NH 03768
Phone: (603) 277-9162 Fax: (603) 484-8282
MonarchFamilyMedicine.com

AUTHORIZATION FOR VERBAL COMMUNICATION

This authorization will cover in person communication, telephone communication and the ability to leave voice mail messages.

1. **Patient Information**:

Name: _____
Date of Birth: _____

2. **Verbal Communication with**

a. Name: SELF
Phone: (_____) _____
Relationship: SELF

b. Name: _____
Phone: (_____) _____
Relationship: _____

c. Name: _____
Phone: (_____) _____
Relationship: _____

d. Name: _____
Phone: (_____) _____
Relationship: _____

3. **Purpose of Communication**

Continuing care.

Other: _____

4. **This authorization will expire in one year from signature unless otherwise indicated below.**

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You have the right to revoke this authorization, in writing, at any time before it ends. Please initial a choice below.

____ Continue indefinitely, until revoked in writing, or termination of doctor-patient relationship.

___ Other: _____

_____

In accordance with the conditions listed above, I authorize the verbal use and/or disclosure of my medical information. No copies of medical records may be released.
I understand that I am not required to sign this release to receive treatment.
This authorization includes disclosure of information regarding psychiatric consults and mental illness, developmental disabilities, alcohol or drug treatment, AIDS or AIDS-related illness, sexually transmitted infection, and/or HIV test results unless I limit the disclosure to exclude the following:

Signature of Patient/Representative:
_____

Date: _____

If signed by person other than the patient, print name and state relationship and authority to do so:

Print Name: _____
Relationship: _____

Patient is: ____ Minor ____ Incompetent / Incapacitated
Legal Authority: ___ Legal Guardian ___ Parent of Minor ___Health Care Agent