UKHealthCare

Place Label Here

q University of Kentucky Hospital A.B. Chandler Medical Center
q UK HealthCare Good Samaritan Hospital
q UK HealthCare Ambulatory Services
q UK College of Dentistry

PERMISSION TO COMMUNICATE HEALTH INFORMATION

Date:_____ Time:_____

Note to Staff: This form does not constitute an authorization for release of written information. Only authorized personnel may release written information and then pursuant to University policies.

	YES	NO
May we leave information regarding your diagnosis, treatment and follow-up on your home answering machine? (Pt must provide number _____)		

May we discuss your diagnosis, treatment, and follow-up with the family member(s) and/or caregiver(s) listed below:

Name (Please print)	Phone

This authorization applies to this treatment area only and will remain in effect until I give a written or verbal notice to revoke it.

Patient Signature/Patient Representative **Date**

Verbal Authorization From Patient Received By **Date**