MoZaic Care

AUTHORIZATION FOR VERBAL DISCUSSION OF PROTECTED HEALTH INFORMATION

Patient Name: …….. Date of Birth: ……

Address: …….. Apt/Unit: ……

Home Phone: …….. Cell Phone: ……

I authorize MoZaic Care to discuss my health information, in person or by telephone, with the following person/s involved in my medical treatment and care:

Name: ……

Relationship: …… Phone Number: ……

Name: ……

Relationship: …… Phone Number: ……

This authorization will automatically **expire within one year from the date of signature**. I understand that I have the right to revoke this authorization at any time, except where information has already been released. My revocation must be submitted in writing, signed by me and sent to MoZaic Care.

Patient Signature: …… Date: ……