CUCAMONGA VALLEY™ MEDICAL GROUP
treated like family

Consent for Verbal Release of Health Information

PATIENT'S FIRST AND LAST NAME

SOCIAL SECURITY NUMBER

STREET ADDRESS

CITY

STATE

ZIP

PHONE

CELL

BIRTHDAY

I authorize Cucamonga Valley Medical Group to discuss my medical history diagnosis, treatment and prognosis with the individual listed below in per- son or by phone. I agree to the verbal release of past, current or future visits in order to allow the individual listed below to participate in my care.

NAME

RELATIONSHIP TO PATIENT

HOME ADDRESS

CITY

STATE

ZIP

HOME PHONE

CELL

Information related to Mental Health, Chemical Dependency, or HIV Testing, and/or Therapy will normally only be released to the patient. Please initial below if you wish to release this information to the individual listed above.

INITIALS **Mental Health Information**

INITIALS **Chemical Dependency Information**

INITIALS **HIV Testing and/or Therapy**

PATIENT, PARENT OR GUARDIAN (PLEASE PRINT)

SIGNATURE OF PATIENT, PARENT, OR PERSON AUTHORIZED TO SIGN FOR PATIENT

DATE

SIGNATURE OF WITNESS TO SIGNING

DATE

This authorization does not permit the release of any written information to the individual listed. Authorization will expire in one year from signature unless otherwise indicated below.

☐ INDEFINITE *(NEVER EXPIRES)*

☐ ENDS ON

DATE

Revocation: You have the right to revoke this authorization, in writing, at any time before it ends. However, your written revoca- tion will not affect any communication of your information that Cucamonga Valley Medical Group has already disclosed. Your revocation must be made in writing and addressed to any of our locations.