Valid only at Bryan Health location where patient is receiving services and signs this form.

BRYAN PHYSICIAN NETWORK

- ☐ Bryan Urgent Care - LifePointe
- ☐ Bryan Urgent Care - NorthPointe
- ☐ Bryan Urgent Care - Southeast
- ☐ Family Medicine of Lincoln
- ☐ Southeast Lincoln Family Medicine & Internal Medicine
- ☐ Bryan Heartland Psychiatry
- ☐ Bryan Women's Care Physicians
- ☐ Bryan Neurology
- ☐ Holmes Lake Family Medicine & Internal Medicine
- ☐ Complete Endocrinology
- ☐ Nebraska Internal Medicine
- ☐ Bryan Heart
- ☐ Center for Maternal & Fetal Care
- ☐ Lincoln Aesthetic Surgical Institute
- ☐ NorthPointe Family Medicine
- ☐ Prairie Center Internal Medicine & Nephrology

BRYAN HEART

- ☐ Bryan Heart

MERRICK and Surrounding Area

- ☐ Central City Clinic
- ☐ Fullerton Clinic
- ☐ Merrick Medical Center

CRETE and Surrounding Area

- ☐ CMAC - Hospital
- ☐ CMAC - Clinic
- ☐ Wilber Medical Clinic
- ☐ Friend Medical Clinic

VERBAL COMMUNICATION AUTHORIZATION

Patient Name: _____ Date Of Birth: _____

❑ **DO NOT** leave clinical information on my voicemail or answering machine.

❑ **DO NOT** speak to anyone about my health status.

❑ I authorize Representatives of Bryan Health to leave information regarding my status as a patient on my voicemail or answering machine. I understand this information may include health status and/or financial information.

Bryan Health may communicate information to the following people regarding my care as needed:

				Type of information			
				All	Scheduling/ Appointments	Medical	Billing/ Insurance
Name: _____	Relationship: _____	Phone Number: _____		☐	☐	☐	☐
Name: _____	Relationship: _____	Phone Number: _____		☐	☐	☐	☐
Name: _____	Relationship: _____	Phone Number: _____		☐	☐	☐	☐
Emergency Contact Name: _____	Relationship: _____	Phone Number: _____		☐	☐	☐	☐

This authorization is limited to the Bryan Health location checked above. I understand I have a right to revoke this authorization by providing written notice to Bryan Health.

The information used or disclosed under this authorization may be subjected to re-disclosure by the recipient and no longer protected by federal privacy laws.

This form is not a substitute for a **Patient Authorization for Disclosure of Health Care Form**.

Patient or Authorization Representative Signature: _____ Relationship: _____ Date: _____

* D T M 0 1 8 3 *

Place Patient Label Here

EPIC: Patient level to Verbal Communication Authorization - Scan
Form M5184 (Rev. 09/2020)