

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
- Bryan Heart
- Center for Maternal & Fetal Care
- Lincoln Aesthetic Surgical Institute
- NorthPointe Family Medicine

- Prairie Center Internal Medicine & Nephrology
- Nebraska Internal Medicine
- Family Practice of Waverly
- Capital Foot and Ankle
- Cheney Ridge Family Medical Clinic
- Surgery Group of Grand Island

BRYAN HEART

- Bryan Heart

MERRICK and Surrounding Area

- Central City Clinic
- Fullerton Clinic
- Merrick Medical Center

CRETE and Surrounding Area

- CAMC - Hospital
- CAMC - 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: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____	Relationship: _____	Phone Number: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____	Relationship: _____	Phone Number: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency Contact Name: _____	Relationship: _____	Phone Number: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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: _____

Bryan Health

VERBAL COMMUNICATION AUTHORIZATION

