



PERMISSION FOR VERBAL COMMUNICATIONS

(print name of patient or place patient label here)

(birthdate)

(street address)

(city, state, zip code)

(phone number)

I permit Dean Health Systems, Inc. or St. Marys Dean Ventures, Inc., their physicians, nurses, and other personnel ("Health Care Providers") to discuss health information, in person or by telephone, with the following family members or friends involved in my medical care: (List family members/friends and state the person's relationship to the patient).

This authorization is limited to discussions regarding the following medical condition(s):

(If no limitations are listed, discussions will be permitted regarding any medical condition for which the patient has received care.)

Table with 3 columns: Name, Phone Number, Relationship. Two rows for listing individuals.

Release of information under this document is limited to verbal discussions with my Health Care Providers. This document does not permit release of any written health information to the individuals named above.

This authorization is limited to the following timeframe from (date) to (date). If no dates are indicated, this form will remain in effect for an unlimited amount of time.

If, at any time, I do not want verbal discussions to be permitted between my Health Care Providers and any of the individuals named above, I must notify my Health Care Provider by contacting the Medical Records Department at any Dean or St. Marys Dean Ventures site.

Patient's Signature: Date:

If this Release is signed by a representative on behalf of the patient, complete the following:

Representative's Name:

Relationship to Patient:

INSTRUCTIONS: Please print, sign and send to one of the following locations

Table with 2 columns: Dean Health System (1313 Fish Hatchery Road, Madison, WI 53713) and St. Marys Dean Ventures (Send to the Dean / St. Marys Regional Clinic where you receive care. Go to www.deancare.com/dhs/locations/ for clinic addresses).