COMMUNICATION AUTHORIZATION

Texas Speech Pathways will not speak to anyone other than patient/legal guardian unless this form is signed.

Permission to Verbally Discuss Protected Health Information with Family members/caretakers, other than legal guardian/patient.

This does not authorize release of copies of medical records without a signed Authorization to Release Medical Records by patient or guardian.

Patient Information:

Name: Last, First, MI	Date of Birth:
Address	City, State

I give permission for Texas Speech Pathways to VERBALLY share the information I have checked with the family, friends or others that I have identified below as being involved in my health care, care coordination or payment of my health care. (check all that apply) This form does not authorize releasing copies of my records.

___ Scheduling/Appointment information ___ Medical information, (including diagnosis and treatment plan)

___ Billing and payment information ___ Other (describe):____________________________

Please check all boxes that Texas Speech Pathways may use for communications:

□ Telephone □ Video Conferencing □ Mail

□ Voicemail □ Email □ Secured Messaging

Texas Speech Pathways has my permission to discuss the above information with the following family, friends and other people. This information is directly relevant to their involvement in my health care (or payment for that care).

Your Protected Health Information Designees: If you are not available at the time we call, please list below those individuals (designees) with whom we can leave a message or briefly discuss your medical information (e.g. scheduling changes, testing results, therapist changes, billing information).

Note: Person(s), (designee) will also be able to call the office on your behalf. Please print the name and relationship to you/patient of each designee below:

Designee Name:	Relationship to Patient:
Designee Name:	Relationship to Patient:

I understand that I have the right to revoke my permission at any time except where Texas Speech Pathways has already made disclosures in reliance upon this request. I understand this permission remains in effect until the time I revoke it in writing.

_____ Check here if you do not want your therapy information discussed with anyone other than yourself.

Signature of Patient/Legal Guardian	Date: