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# AUTHORIZATION FOR VERBAL RELEASE OF INFORMATION

**Authorization for Use or Disclosure of Information for Van Family Medical**

**I, , hereby authorize Van Family Medical to disclose my protected health information to:**

**1. 2.**

\*\* This protected health information is being used or disclosed for the following purposes: Information directly related to Treatment, Payment and/or Health care operations. The information may include, but not be limited to medical information, demographics, insurance, dates of service, type of service, charges and reasons for denial or patient responsibility, etc.

I understand that I have the right to revoke this authorization, in writing, at any time by sending Xpress Family Clinic such written notification.

# Signature of Patient /Representative Date Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicates that you have been given the opportunity to review and request a copy

of the Van Family Medical Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in Van Family Medical Notice of Privacy Practices, please do not hesitate to contact a clinic representative.

**Patient Name (Printed):**

**Signature:**

**Date Notice Received:**

**If Patient Representative, Name & Relationship**