Hospice of the Comforter
FLORIDA HOSPITAL CONNECTED CARE

Authorization for Communication with Patient Caregivers

I, ____, ______________________
(Patient or patient's legal representative's name) *(Date of birth)*

authorize Hospice of the Comforter staff and volunteers to use verbal communication to disclose my health information as it pertains to hospice care and treatment. Hospice of the Comforter may verbally disclose my health information to the following individuals:

______________________________ ______________________________
Primary caregiver name/relationship Address/phone
____

______________________________ ______________________________
Name/relationship Address/phone
____

______________________________ ______________________________
Name/relationship Address/phone
____

______________________________ ______________________________
Name/relationship Address/phone
____

______________________________ ______________________________
Name/relationship Address/phone
____

I understand that I have a right to revoke this authorization at any time, and that if I revoke this authorization, I must do so in writing and present my written revocation to Hospice of the Comforter. I also understand that the revocation will not apply to information released prior to receipt of such revocation.

This authorization will expire one year after the date it is signed and dated. I understand authorizing the verbal disclosure of my health information is voluntary. I need not sign this form to ensure health care treatment.

______________________________ ______________________________
Signature of patient Date

____
Printed name of patient

______________________________ ______________________________
Signature of legal representative Date

______________________________ ______________________________
Printed name of legal representative Address/phone of legal representative
____

______________________________ ______________________________
Signature of Hospice of the Comforter representative Date

____
Printed name of Hospice of the Comforter representative

Patient Name ______________________
Patient # ______________________