

*Treasure Coast  
Surgical Center, Inc.*

1811 S. 25th Street • Fort Pierce, FL 34947 Phone: (772) 467-1960

**Permission to Verbally Discuss Health Information**

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In limited cases, we may provide health information to family members, or close friends who are directly involved in your care or the payment for your health care, **unless you tell us not to**. For example, we may tell a friend who asks for you by name where you are in our facility, and we may allow a friend or family member to pick up a prescription for you. We may also contact a family member if you have a serious injury or in other emergency circumstances. We may discuss medical information in the presence of a family member or friend **if you are also present and indicate that it is okay to do so**.

You can give us permission to discuss information about you with family, friends and others you designate who are involved in your care or concerned about your health status and may ask about your condition or need information **when you are not present**. You can tell us who we may talk with about your medical care, including your appointment and scheduling information, lab and test results, treatment information and billing information. This does not mean that the person will have access to your medical records. Permission to disclose or release medical records is handled completely separate.

Complete this form to let us know to whom we may speak about your information. Check the appropriate boxes to indicate what information we may discuss. You may also send us a letter with this information. Here are some examples of when it might be useful to you to release information:

- If you want a relative or friend to help understand medical treatment instructions
- If a relative or friend is helping with billing questions
- If a friend or relative calls to verify an appointment time
- If a relative or friend comes in and asks if you are here and in or out of surgery or the procedure room.

If you change your mind when you have another appointment with us, you can complete a new permission form. You must notify us **IN WRITING**.

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**I give permission to the Surgical Center to VERBALLY discuss the following information about me (check all boxes that apply) with the following person(s)**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone numbers: Work \_\_\_\_\_ Mobile \_\_\_\_\_ Home \_\_\_\_\_

- Appointment information
- Medical information, including my symptoms, diagnosis, medications, and treatment plan
- Lab/test results
- Billing and payment information
- My location in the facility, whether I am waiting to go into a surgery or procedure room, whether I am in a surgery or procedure room, whether I am in recovery, whether I have been released and discharged.

I understand that I have the right to revoke my permission at any time except where the Surgery Center has already made disclosures relying upon this permission request. **I understand I must notify the Surgery Center in writing if I want to revoke my permission.**

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Signature of Patient/Authorized Representative

Date

PLACE RECORD ID STICKER HERE