AdventHealth
Hospice Care
Central Florida

Authorization for Communication with Patient Caregivers

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

authorize AdventHealth Hospice Care staff and volunteers to use verbal communication to disclose my health information as it pertains to hospice care and treatment. AdventHealth Hospice Care 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 AdventHealth Hospice Care. 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 AdventHealth Hospice Care representative	Date
Printed name of AdventHealth Hospice Care representative	

Patient Name _____

Patient # _____