Christopher Kye, MD, PA
900 N.W. 17th Avenue, Suite 201
Delray Beach, FL 33445
Phone # 561-501-5761 Fax # 561-501-5720

Authorization to Verbally Discuss Health Information

I _____*(please print name)* _____ *(date of birth)*

hereby authorize Dr. Christopher Kye and office personnel to discuss health information, in person or by telephone, with the following family members or friends directly involved in my medical care if necessary.

Name	Phone number	Relationship
1.		
2.		
3.		
4.		

I UNDERSTAND THAT THIS COMMUNICATION:

- May include information on diagnosis/treatment related to psychiatric or psychological conditions, appointment and billing information, drug and/or alcohol abuse, pregnancy, sexually transmitted diseases (STD) acquired immune deficiency syndrome (AIDS), and/or HIV status and/or other "sensitive information"

I UNDERSTAND THAT THIS AUTHORIZATION IS:

- Limited to verbal and written conversations (including telephone and email) and does not permit or authorize the release of any written health information to any of the individuals named above
- Remains in effect indefinitely unless otherwise specified by me
- Is voluntary and my treatment and fees are not conditional on my signing this authorization

I FURTHER UNDERSTAND:

- If I no longer want verbal discussions to be permitted between Dr. Kye and any of the individuals named above, I have the right to revoke this authorization at any time. I must notify Dr. Kye in writing to do so.
- Written revocation does not affect any disclosures of medical information that have already been discussed.

By signing below, I acknowledge that I have read this document in full and understand the terms of this authorization to verbally discuss my health information. All of my questions have been answered satisfactorily.

_____ _____/_____/_____

(Signature of patient, parent, or legal representative) (Today's date)

_____ (Relationship to patient)