

VERBAPROMPT, LLC MEDICAL TRIAGE INFORMATION

RELEASE FORM

I _____ AUTHORIZE VERBAPROMPT, LLC TO E-MAIL OR FAX MY PREVIOUSLY PROVIDED TRIAGE INFORMATION IN THEIR POSSESSION TO ALL: PHYSICIANS, EMERGENCY MEDICAL TECHNICIANS, EMERGENCY ROOM PERSONNEL, HOSPITALS, HEALTH CLINICS, PHARMACISTS AND DENTISTS WHO CALL IN FOR MY INFORMATION (FOR THE PURPOSE OF MY CARE) AND VALIDATE MY SECURITY CODE. I HAVE BEEN INFORMED OF MY RIGHTS (HIPAA REGULATIONS) REGARDING MY PERSONAL INFORMATION AND GIVE VERBAPROMPT, LLC AND ALL THOSE MENTIONED IN THIS RELEASE, PERMISSION TO SHARE THAT INFORMATION ONLY AMONG THEM FOR MY HEALTH AND SAFETY. THIS SERVICE ENHANCES THE QUALITY OF MY HEALTH CARE AND ASSISTS THESE MEDICALLY PROFESSIONAL PEOPLE TO PROVIDE FOR MY HEALTH AND SAFETY.

MY NAME _____ DATE _____

ADDRESS _____ TELEPHONE _____

SIGNATURE _____ WITNESS _____

REV. 4/03

VERBAPROMPT, LLC MEDICATION INFORMATION

PATIENT RELEASE FORM

I _____ AUTHORIZE AND GIVE CONSENT FOR MY PHARMACY, ALL PHYSICIANS, DENTISTS, EMERGENCY ROOM PERSONNEL, EMERGENCY MEDICAL TECHNICIANS, HOSPITALS, HEALTH CLINICS AND TRIAGE CENTERS TO ACCESS MY PERSONAL TRIAGE INFORMATION AND VALIDATE MY SECURITY CODE, (FROM VERBAPROMPT, LLC) IN ORDER TO MEET MY NEEDS WHILE IN THEIR CARE. THEN TO SHARE ANY INFORMATION REGARDING ANY MEDICATION OR MEDICAL CHANGES WHILE IN THEIR CARE, WITH VERBAPROMPT, LLC FOR THE PURPOSE OF COMMUNICATING WITH DESIGNATED OTHERS IN MY LIFE. I HAVE BEEN INFORMED OF MY RIGHTS (HIPPA REGULATIONS) REGARDING MY PERSONAL INFORMATION AND GIVE ALL OF THE ABOVE PROVIDERS MENTIONED PERMISSION TO SHARE MY INFORMATION WITH VERBAPROMPT LLC, AND EACH OTHER, AS THIS SERVICE ENHANCES THE QUALITY OF MY HEALTHCARE AND ASSISTSTHE MEDICAL PROFESSIONAL PEOPLE, WHO PROVIDE FOR MY HEALTH AND SAFETY.

SIGNATURE _____ PRINT NAME _____

ADDRESS _____ TELEPHONE _____

WITNESS _____ DATE _____

REV 4/03