



MRN: \_\_\_\_\_  
Office Use Only

**Email & Verbal Communication Consent (Limited PHI Release)**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Purpose:** I authorize Noble Community Clinics (Noble) to communicate by email and verbal exchange (phone or in-person discussion) with the person(s) listed below for limited purposes such as coordination of care, scheduling, or brief clinical updates. This does not authorize release of full medical records or paper/electronic chart copies.

**Authorized Recipient(s)**

1) Name: \_\_\_\_\_ Organization: \_\_\_\_\_ Role: \_\_\_\_\_

Email: \_\_\_\_\_ Phone Number: \_\_\_\_\_

2) Name: \_\_\_\_\_ Organization: \_\_\_\_\_ Role: \_\_\_\_\_

Email: \_\_\_\_\_ Phone Number: \_\_\_\_\_

I understand that if the recipient is not a HIPAA-covered entity, information shared may be re-disclosed and no longer protected by HIPAA.

**Communication Methods**

**Email:**

I understand that email may involve privacy risks. HHS permits providers to use email with reasonable safeguards (verifying addresses, limiting PHI, using encryption when available). I accept these risks and authorize email communication. *All emails will be sent as encrypted unless requested otherwise.*

**Verbal Communication:**

I authorize limited verbal communication with the individuals listed above for the purposes stated. Only the minimum necessary information will be shared.

**Expiration & Revocation**

This consent expires on: \_\_\_\_\_ (maximum one year from signature)

I may revoke this consent in writing at any time; prior communications cannot be retracted.

**Other Acknowledgments**

- My care will not be conditioned on signing this consent.
- Some states require explicit opt-in for email; I am opting in by signing.
- Alternative communication options (MyChart) are available.

\_\_\_\_\_  
**Patient Signature/Parent if Minor/Power of Attorney/Guardian**

\_\_\_\_\_  
**Date**