I hereby authorize my psychiatrist and/or members of Green Oaks Hospital treatment team to discuss my treatment with the following:

NAME	RELATIONSHIP	PHONE NUMBER Home: Work:	RESCINDED
NAME	RELATIONSHIP	PHONE NUMBER Home: Work:	RESCINDED
NAME	RELATIONSHIP	PHONE NUMBER Home: Work:	RESCINDED
NAME	RELATIONSHIP	PHONE NUMBER Home: Work:	RESCINDED
NAME	RELATIONSHIP	PHONE NUMBER Home: Work:	RESCINDED
NAME	Therapist	PHONE NUMBER Office:	RESCINDED
WOULD YOU LIKE YOUR TREATMENT MANAGER TO CONTACT YOUR PCP? ☐ Yes ☐ No PRIMARY CARE PHYSICIAN NAME	Primary Care Physician	PHONE NUMBER Office:	RESCINDED
WOULD YOU LIKE YOUR TREATMENT MANAGER TO CONTACT YOUR OUTPATIENT PSYCHIATRIST? ☐ Yes ☐ No OUTPATIENT PSYCHIATRIST NAME	Psychiatrist	PHONE NUMBER Office:	RESCINDED

I understand that I can revoke this authorization at any time except to the extent that action has been on this authorization.

DATE	TIME
PATIENT / PARENT / GUARDIAN / CONSERVATOR **X**	IF OTHER THAN PATIENT, INDICATE RELATIONSHIP
SPOUSE (If Married / Available) **X**	WITNESS (To Signature Only) **X**

GREEN OAKS HOSPITAL
7808 Clodus Fields Drive ● Dallas, TX 75251

PATIENT IDENTIFICATION

AUTHORIZATION FOR VERBAL RELEASE OF MEDICAL INFORMATION

COA