

# WVU Medicine Enterprise Customer Service Verbal Communication Form

\*Please complete and return this form to WVU Medicine PO Box 8031 Morgantown, WV 26507\*

I, the undersigned, wish to grant permission to WVU Medicine Enterprise Customer Service Staff to verbally communicate with the following person(s):

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(List the name and relationship to you)

about my billing account information in full detail, which could include **dates of service, reason for the visit, diagnosis, charge information, insurance information and the right to make a payment arrangement on my behalf.**

Patient Name (Print): \_\_\_\_\_ EPN: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Patient/Guardian Signature (age 10 and up): \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

*Note: This communication agreement is valid one year from signature date. Please understand that by requesting access to verbal information exchange, the individual representing you will potentially have access to **diagnoses, lab values, appointments, and potentially sensitive medical information that is discussed** (for example, there could be information pertaining to behavioral and mental health treatment, Family Planning, pregnancy, alcohol, drug, and sexually transmitted diseases).*

For Office Use:

Please make a copy of this form for patient's records and mail or fax the original to Health Information Management to put on file in patient's chart.