AUTHORIZATION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION

Patient Name (Last, First MI)	Date of Birth	Medical Record Number	
Patient Street Address	City	State	Zip Code
Home Phone	Work or Cell Phone (circle one)		

At my request, I give Grant Regional Health Center (hospital and clinic) permission to VERBALLY discuss the following medical and billing information about me (check all boxes that apply):

- ☐ Scheduling/Appointment information
- ☐ Medical information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Lab/test results
- ☐ Behavioral health information, including my symptoms, diagnosis, medications and treatment plan
- ☐ HIV related information (AIDS related testing)
- ☐ Billing and payment information
- ☐ Other (describe): _____

Verbal Communication Between:

Grant Regional Health Center **and:** Name:_____Relation: _____

Street Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone:_____

Leave VOICE MAIL at the Following Phone Number(s): _____

*Voice mail includes any information, unless limited below:

Limit voicemail only to information specified: _____

AND/OR

- I understand that I have the right to revoke my permission at any time except where Grant Regional Health Center has already made disclosures in reliance upon this request. I understand I must notify Grant Regional Health Center in writing if I want to revoke my permission
- I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand this consent for release of alcohol and/or drug abuse information is subject to revocation at any time except to the extent that the program or person, which is to make the disclosure, has already acted in reliance on it.
- I understand that Grant Regional Health Center may not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.
- I understand upon my request I am able to receive a copy of this letter after I have signed it.
- I understand a photocopy or fax of this form is the same as the original.
- I understand that: (1) my HIV test results may be released without my authorization to person/organizations that have access under Wisconsin law; and that (2) a list of those persons/organizations is available upon request.

X_____ _____/_____/_____ _____

Signature (Patient/Parent of Minor or Personal Representative) | Date | Witness (Signature by mark must be witnessed)

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INFORMATION SHEET

Grant Regional Health Center knows that privacy regulations have an impact on our customer service to you, especially when it comes to discussing information about you with family, friends and others you designate who are involved in your care. By completing the Authorization to Verbally Discuss Protected Health Information Form, it will allow us to talk about your medical care to those you have designated. This includes appointment and scheduling information, lab and test results, treatment information, and billing information.

How can I give others permission to get verbal information about me?
Complete the Authorization to Verbally Discuss Protected Health Information form to let us know to whom we may speak to about your information. Check the appropriate boxes to indicate what information we may discuss.

How is the information in the form used?
Anytime that your designated person calls or makes a request on your behalf, we will verify the individual has your permission to receive the information and then we will share the information.

What are some examples of when this might be useful?

- If any elderly patient wants an adult child to help understand medical treatment instructions
- If an adult child is helping with billing questions
- If a friend is helping an elderly patient with health issues
- If a college student wants information shared with parents
- If an adult child calls to find out his/her parent's appointment time

Can the person I designate also get copies of my medical records?
No they can only receive verbal information. To get copies of your medical records, you must complete a separate Authorization For Use and Disclosure form available at your treating facility.

Voice Mail Messages: Grant Regional Health Center recognizes confidentiality as a very important part of our relationship with you. To protect your confidentiality, we will not routinely leave messages on your personal messaging system (or with your spouse, family members, etc.) unless you specifically give permission to do so.

What if I change my mind?
You can change or revoke (stop) this process at any time by notifying in writing at the address below.

What happens if I don't complete this form?
We will continue to protect your private health information as required by law. Completion of this form is optional.

Where do I send the completed form or any changes?
Grant Regional Health Center
Health Information Management Department
Attn: Release of Information
507 S Monroe St
Lancaster, WI 53813

Call (608) 723-2134 for questions