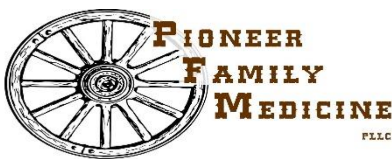


20 E. J Street Suite 2B
Deer Park, WA 99006
P – (509) 276-8012
F – (509) 276-8350

Authorization for Verbal Communication

Patient Information:

Name – Last, First, MI:		
Street Address		
City:	**State:**	**Zip:**
Date of Birth:	**Phone number:**	

At my request, I give Pioneer Family Medicine permission to **VERBALLY** discuss the following medical and billing information about me (check all boxes that apply):

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

I, (name)__________________________________, (date)_________________, authorize Pioneer Family Medicine , their physicians, nurses, and other personnel ("health care providers") to discuss health information, in person or by telephone, with the following **family members or friends directly involved in my medical care.**

Name (please print):	**Phone number:**	**Relationship:**
1)_____________________________________	________________________	_________________________
2)_____________________________________	________________________	_________________________

Leave VOICE MAIL at the Following Phone Number(s):____
*Voice mail includes any information, unless limited below:
Limit voicemail only to information specified:____

I UNDERSTAND THAT THIS COMMUNICATION:

- May include information on diagnosis/treatment related to psychiatric or psychological conditions, drug and/or alcohol abuse, pregnancy, sexually transmitted diseases (STD) acquired immune deficiency syndrome (AIDS), and/or HIV status and/or other "sensitive information."

I UNDERSTAND THAT THIS AUTHORIZATION IS:

- Limited to verbal and telephone conversations and des not permit or authorize the release of any written health information to any of the individuals named above.
- Limited to the specific timeframe determined by me and that if I do not specify a specific timeframe, this authorization will remain in effect for an unlimited amount of time.
- **Specific Time Frame Listed: Start Date: _________________ End Date:__________________________**

I further understand that if, I do not want verbal discussions to be permitted between my health care provider and any o the individuals named above I have the right to revoke this authorization, in writing at any time. I understand that this written revocation will **not** affect any disclosures of my medical information that the person(s) and/or organization(s) listed on this authorization that have already made, in reliance on this authorization, before the time I revoke it.

This document has been explained to me and all of my questions have been answered satisfactorily.

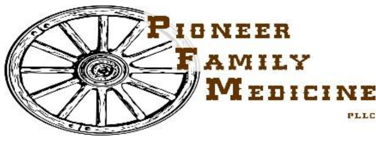
(Signature of patient or legal representative) (Date)

____ ____________________

(Relationship to patient)

____

This authorization is NOT valid unless it is signed and dated by the patient or their representative



INFORMATION SHEET Pioneer Family Medicine 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. Release of information under this document is limited to **VERBAL** discussions only and does not authorize the release of written or **copies** of medical records to the individuals listed. Please use **the Pioneer Family Medicine Authorization for the Use, Disclosure or Release of Information Form.**

Who May sign this form?

1. Generally, all patients 18 years of age or older must sign for communication of their own health information unless the following conditions apply:
   - The patient is incompetent
   - The patient is disabled and cannot sign the form.
2. All persons signing for communication of health information on behalf of the patient must state their relationship to the patient and provide proof of legal authority of their capacity to act for the patient.
3. Minors: Patient under 18 years of age must sign for communication of their health information in the following cases:
   - Alcohol or other drug abuse: age 13 or older
   - Mental health: age 13 or older
   - Sexually transmitted disease: age 14 or older
   - Any age for reproductive health

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:
Pioneer Family Medicine 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?
Pioneer Family Medicine Health Information Management Department Attn: Release of Information PO Box 1988, Deer Park, WA 99006 or call (509) 276-8012,