STEVENS COMMUNITY MEDICAL CENTER

400 E. 1st St., Morris, MN 56267 (320) 589-1313

Authorization to Verbally Disclose Protected Health Information to Family and Friends

(complete fields or place patient label)

Patient Name:_____

DOB:_____

Instructions: Please read carefully and complete the form:

Stevens Community Medical Center values your privacy and we want to protect it as much as possible. By signing this form, **you authorize Stevens Community Medical Center to disclose information verbally** (e.g., phone, face to face) to the individual(s) you list below. This is separate from your emergency contact(s) and separate from an Authorization and Release of Health Information.

Individual(s) Authorized to Receive Information Verbally:

Name *(First, Middle, Last)*	Birth Date *(mm-dd-yyyy)*
Relationship to Patient: ❒ Parent ❒ Spouse ❒ Child ❒Sibling ❒ Other:	
Name *(First, Middle, Last)*	Birth Date *(mm-dd-yyyy)*
Relationship to Patient: ❒ Parent ❒ Spouse ❒ Child ❒Sibling ❒ Other:	
Name *(First, Middle, Last)*	Birth Date *(mm-dd-yyyy)*
Relationship to Patient: ❒ Parent ❒ Spouse ❒ Child ❒Sibling ❒ Other:	
Name *(First, Middle, Last)*	Birth Date *(mm-dd-yyyy)*
Relationship to Patient: ❒ Parent ❒ Spouse ❒ Child ❒Sibling ❒ Other:	
Name *(First, Middle, Last)*	Birth Date *(mm-dd-yyyy)*
Relationship to Patient: ❒ Parent ❒ Spouse ❒ Child ❒Sibling ❒ Other:	

I understand this authorization applies to all Stevens Community Medical Center services and locations. The information to be released may consist of my past, present, or future health information including treatment and billing records. These records may contain information related to behavioral/mental health care, substance abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing and sent to Health Information Management.
Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by state and federal law. If you want to change/update individuals who can receive verbal information, you must submit a new Authorization to Verbally Disclose Protected Health Information form. Stevens Community Medical Center will honor the most recent version of this form retained in the electronic medical record.

*This authorization will not expire unless revoked by you or your legal representative or upon notification of death.

Attention: If this section is incomplete, this form may be invalid. By signing, you agree that you understand and accept the terms of this form.			
Patient/Legal Representative Signature (required)			Date (required) *(mm-dd-yyyy)*
Print Name of Person Signing (If not Patient) *(First, Middle, Last)*			
Relationship to Legal Representative to Patient (if applicable)			
Patient Street Address			
City	State	ZIP Code	Phone