AUTHORIZATION TO VERBALLY DISCUSS MY HEALTHCARE WITH OTHERS

This form gives permission for Women's Health Center of Southern Oregon to VERBALLY discuss information regarding medical treatment or conditions which may include my protected health information.

Print Patient Name:____ Date of Birth:_______________________

By initialing below, I am allowing this specific information to be shared with individual(s) involved in my care:

________**All Healthcare/Financial Information**	_______Appointment Information (time/date/provider/length; does not include WHY patient is being seen)
________ Insurance Information	_______Billing/Collection Information
________Lab Results	_______Diagnosis and Treatment Information
________ Other ____	

I authorize the above information to be verbally discussed with the following individual(s):

Name of Individual	Relationship\
____________________________________	____________________________
____________________________________	____________________________
____________________________________	____________________________

By signing this form, I understand that it ***does not permit the release of my medical records***. All requests for medical records will be processed by completing and signing an Authorization to Release Protected Health Information form.

This form may be revoked upon request and/or updated as needed by completing a new form. Unless revoked in writing or on this form, this authorization expires ______________________(insert date or event). If no date or event is indicated this Authorization will expire in 5 years from date of signing.

I have read and understand this Authorization.

____ ______________________

Signature of Patient Date

**********************REVOCATION: I hereby revoke the above authorization*************************

____ ______________________

Signature of Patient Date

Created 10/2017 ap Reviewed by: ___________