



**PROTECTED HEALTH INFORMATION
AUTHORIZED PERSON(S)**

Please print below information

I, _____, hereby authorize release of my Protected Health Information for **verbal discussion only** of my care and treatment to the person(s) specified below (45CFR, 164.502[F] & 164.502[G]):

Authorized family member or person to receive information for the above named patient's care:

Name of Central Contact (other than patient) Relationship to Patient Phone

Others authorized to receive my verbal information (please list names and relationship):

Print Name Relationship to Patient Phone

Print Name Relationship to Patient Phone

NOTE: This form does not give the above referenced persons permission to make health care decisions for the patient or entitle them to paper copies or electronic access of your medical record. We will not release via the telephone or any other means of communication any information to any friends or family members not listed above unless the patient has an opportunity to object and does not (documented) or if it is reasonable to infer that the patient does not object such as when a patient brings a spouse into the room when treatment is being discussed. Exception: if the release is needed in emergency situations.

- ◆ **May we include you in the clinic or hospital directory?** Yes No
(Example: If you are in our clinic/hospital seeking treatment and a spouse or other family member calls to inquire if you are still there, can we say yes or no?)
- ◆ **Leave message on answering machine or voice mail?** Yes No
(Example: We may leave message reminders, scheduling changes or notices that lab results are in on your answering machine. Would this process be acceptable, yes or no?)
- ◆ **Leave message for patient to return call?** Yes No
(Example: We may leave a message regarding appointment reminders, scheduling changes or notices that lab results are in with an individual who answers the phone. Would this process be acceptable, yes or no?)

NOTE: By signing and dating this Protected Health Information Authorized Person(s) form, I revoke all previously signed Protected Health Information Authorized Person(s) forms.

Patient Signature _____ Date _____

Personal Representative _____ Relationship to Patient _____
(PRINTED Name)

NOTE: Except to the extent that action has already been taken in reliance on this Protected Health Information Authorized Person(s), at any time I can revoke this Protected Health Information Authorized Person(s) by submitting a new Protected Health Information Authorized Person(s) form or by written notice to the Mercy Health Network clinic where my medical records are kept.

Patient Name: _____

Date of Birth: _____