Appleton Area Health

Authorization to Verbally Disclose Protected Health Information to Family and Friends

(complete fields or place patient label here)

Patient Name: *(First, Middle, Last*)
Birth Date (mm-dd-yyyy)

Instructions: Please read carefully and complete the form.

Appleton Area Heath values your privacy, and we want to protect it as much as possible. By signing this form, **you authorize Appleton Area Health to disclose information verbally** (e.g., via phone, face-to-face) to the individual(s) you list below. This is separate from your emergency contact(s) and separate from an authorization for 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 Appleton Area Health 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 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 redisclosure by the recipient and may no longer be protected by state and federal law. If I want to change/update individuals who can receive verbal information, I must submit a new Authorization to Verbally Disclose Protected Health Information form. Appleton Area Health will honor the most current 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 on this form.			
Patient/Legal Representative Signature (required)		Date (required) (mm-dd-yyyy)	
Printed Name of Person Signing (if not patient) (*First, Middle, Last*)			
Relationship of Legal Representative to Patient (if applicable)			
Patient Street Address			
City	State	ZIP Code	Phone

Send form to:
Health Information Management
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Phone: 320-289-1580
Fax: 320-289-8538
www.appletonareahealth.com