



Gastroenterology/Endoscopy/Pathology

### Authorization of Verbal Disclosure of Protected Health Information

Due to the implementation of the new federal guidelines known as **HIPPA**, we are required to have your signature on file before we are able to verbally discuss any protected health information with any person/s who is not directly involved in your health care (i.e. family members, caregivers etc).

**I hereby give my authorization for verbal disclosure of my protected health information to be disclosed to:**

**Name of person** \_\_\_\_\_

**Relationship** \_\_\_\_\_

**Name of person** \_\_\_\_\_

**Relationship** \_\_\_\_\_

**Name of person** \_\_\_\_\_

**Relationship** \_\_\_\_\_

**Name of person** \_\_\_\_\_

**Relationship** \_\_\_\_\_

\_\_\_\_\_  
**Patient signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Account #**

**\*\* Note: this authorization form expires one year from the date signed, and must be updated on a yearly basis.**