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Authorization of Verbal Disclosure and Protected Health Information

In order to comply with the Federal HIPAA (Health Insurance Portability and Accountability Act) guidelines, we are required to have your signature to verbally discuss any protected health information with persons not directly involved in your health care. (i.e. family members, caregivers)

I hereby give my authorization for verbal disclosure of my protected health information to the following:

Name of person ____

Relationship to you________________________ Phone________________

Name of person ____

Relationship to you________________________ Phone________________

Name of person ____

Relationship to you________________________ Phone________________

Patient Signature__________________________ Date_________________