Black River Health

PERMISSION FOR VERBAL COMMUNICATIONS TO DESIGNATED PERSONS

With the implementation of the Health Insurance Portability and Accountability Act (HIPAA), Black River Health requests to have your specific authorization to share any of your Protected Health Information (PHI) with a spouse, family member or other authorized individual.

Patient Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

City, State, and ZIP: _____

I permit Black River Health, their physicians, medical assistants, nurses, and other personnel ("Health Care Providers") to discuss health information, in person or by telephone, with the following designated persons involved in my medical care or the payment for my medical care. I understand that this consent is limited to **verbal discussions only**, is not an authorization (as defined by HIPAA), and does not permit the release of copies of my medical records.

Please list specific names and identify relationships to the patient below.

Name & Relationship	Phone Number	Information to be Disclosed

INFORMATION TO BE DISCLOSED: May include scheduling, financial, medical history of diagnostic and therapeutic information, behavioral health information, developmental disability, HIV and alcohol and drug abuse unless otherwise specified below.

_____

Please indicate below where we may contact you and leave a voice message (telephone answering machine, with significant other, or family member):

Home: _____ Cell: _____

This authorization will expire in one year from the signature unless otherwise indicated below. The patient may withdraw this consent at any time, in person or by contacting Black River Health, Health Information Department at 715-284-5361.

Ends on: (date) _____

Patient's Signature: _____

Print Name: _____ Relationship to patient: _____

Date: _____ Time: _____

Patient is: ☐ Minor ☐ Incompetent/Incapacitated ☐ Legal Guardian ☐ Parent of Minor ☐ Health Care Agent

☐ Parent signature not required for BH information as patient is at least 14 years old.

DISCLAIMER: This form will become null and void upon the death of the above-named patient and will not be honored by Black River Health, Inc.