LAKE ROAD
FAMILY MEDICINE

Release of Verbal Medical Information

_____ _____
Patient Name **Date of Birth:**

The Lake Road Family Medicine clinic restricts the release of protected health information (PHI) to that permitted by patient confidentiality laws. According to HIPAA regulations, permitted reasons for release of PHI include treatment, payment and healthcare operations, or as otherwise allowed by the **specific signed authorization** of the patient or authorized personal representative.

The purpose of this Release of Verbal Medical Information form is to provide our patients an opportunity to permit verbal release of PHI in the following two (2) ways:

I. Permission to Leave a Detailed Message:
I hereby authorize medical providers and personnel of Lake Road Family Medicine to leave a detailed message at the following: **Phone number:** _____and/or **e-mail address:** _____
-or- ☐ **I decline.** Please do not leave me detailed messages.

II. Permission to Verbally Discuss PHI with Family Members/Caregivers
I hereby authorize medical providers and personnel of Lake Road Family Medicine to discuss my protected health information with the following person(s):

Name/Phone number: _____ **Relationship:** _____

Name/Phone number: _____ **Relationship:** _____

Name/Phone number: _____ **Relationship:** _____

-or- ☐ **I decline.** Please do not discuss my care with anyone other than as allowed by HIPAA regulations.

Certain information cannot be released without specific authorization as required by state or federal law. *By initialing the lines below, you authorize the release of the following protected or sensitive information:*

_____ Information regarding the patient's diagnosis and treatment of HIV/AIDS
_____ Psychotherapy notes from a Psychiatrist or Psychotherapist
_____ Treatment for alcohol or drug abuse reports

- This authorization will expire 730 days (2 years) from the date of signing.
- I understand that I have the right to revoke this authorization, in writing, at any time.
- I understand that such a revocation is not effective to the extent that the clinic has relied on the use or disclosure of the protected health information.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by state or federal law.
- This form is not valid unless signed and dated.

_____ _____
Signature of Patient/Personal Representative **Name of Patient/Personal Representative**

_____ _____
Date **Description of Person Representative's Authority**