Authorization to Disclose Verbal Protected Health Information

I, ________________________________, authorize West Bend Family Medicine to disclose and release my protected health information (PHI) as described below to the individual(s) identified. If no contacts are listed, the contact section should be left blank, indicating that West Bend Family Medicine is authorized to discuss my care only with me.
“My care” includes, but is not limited to, appointment information, test results, follow-up care, and any other information related to me as a patient.

____ Authorized to leave detailed messages on your voicemail?

Contact #1 (optional)
Name of Authorized Individual: ____
Relationship to Patient: ____
Phone Number: ____

Contact #2 (optional)
Name of Authorized Individual: ____
Relationship to Patient: ____
Phone Number: ____

Contact #3 (optional)
Name of Authorized Individual: ____
Relationship to Patient: ____
Phone Number: ____

Only initial if the answer is YES to the following questions

____ Authorize the release of Alcohol and substance abuse to all contacts listed above?

____ Authorize the release of Mental Healthcare to all contacts listed above?

____ Authorize the release of HIV and STD to all contacts listed above?

This authorization will remain in effect until changed in writing with the clinic.

Signature: ____________________________________
Today's Date: ____ / ____ / _______

Reviewed by: ___________________________________