Authorization for Verbal Communication of Protected Health Information to Family or Friends

This form documents my request to allow family members and/or friends to be involved in verbal discussions regarding my health care. This authorization must be written, dated and signed by the patient or their legal representative.

Patient's Name *(please print)*:______________________________ Date of Birth:____________________

Other names/nicknames:______________________________ Phone #:____________________

Street Address:____________________________ City, State & Zip Code:____________________________

Email Address:____

Authorization for release of verbal information can be revoked at any time by the patient in writing, but it is NOT retroactive to the release of information made in good faith.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

____________________________________ __________________________

Signature of Patient or Legal Representative Date

1. I authorize Hope Orthopedics of Oregon to discuss protective health information about me with the following individuals:

____________________ | __________________ | __________________ YES | NO

Name Relationship Phone # May be listed as an Emergency Contact

____________________ | __________________ | __________________ YES | NO

Name Relationship Phone # May be listed as an Emergency Contact

____________________ | __________________ | __________________ YES | NO

Name Relationship Phone # May be listed as an Emergency Contact

2. Type of information to be shared or disclosed *(excludes copies of medical records)*:
   ☐ Appointment Information ☐ Prescription Information ☐ **ALL** Information

3. I authorize Hope Orthopedics of Oregon to leave detailed phone messages about my medical and health plan information via:
   ☐ Voicemail on my phone number(s) ☐ With person answering my phone number(s) ☐ Email ☐ Postal Mail
   ☐ All Options

4. Mark this box if you ***do not authorize*** Hope Orthopedics of Oregon to discuss protective health information about me with others. ☐