Authorization to Verbally Discuss Protected Health Information

I authorize Terry Reilly Health Services to **Verbally** share the information I have checked below with those whom I have identified as being involved in my health care, care coordination, or payment of my health care. **This form does not authorize releasing copies of any of my records.** If any of the requested information concerns alcohol or drug abuse treatment, it is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the use or release of medical or other information is **NOT** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

PLEASE PRINT PATIENT INFORMATION **Patient Information:**

Patient Name:			
Address:	City:	State:	Zip Code:
Telephone: ( )	Date of Birth:	Patient ID:	

Information I Authorize For Verbal Disclosure Only:

[ ] Medical information, including my symptoms, diagnosis, medications, test results, and treatment plan.

[ ] Dental information, including my symptoms, diagnosis, medications, and treatment plan.

[ ] Scheduling/Appointment information SELECT ALL THAT APPLY

[ ] Billing and payment information

[ ] Other (describe):

**Check below if you want to include information related to:*

[ ] HIV/AIDS Status [ ] STD Status [ ] Mental Health Information [ ] Alcohol or Substance Use Disorder Treatment

Terry Reilly Health Services is authorized to discuss the above, checked information with all of the following individuals:

Name:	Relationship to Patient:
Address:	
Home/Cell Phone:	Work Phone:
Name:	Relationship to Patient:
Address:	
Home/Cell Phone:	Work Phone:
Name:	Relationship to Patient:
Address:	
Home/Cell Phone:	Work Phone:

My authorization is given freely with the understanding that:

- My information may be subject to re-disclosure by the recipient and may no longer be protected by Terry Reilly Privacy Practices or applicable privacy laws.
- I may revoke this authorization at any time, except where action has already been taken in reliance, provided my revocation is in writing.
- My health care, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
- A photocopy or fax of this authorization is as valid as the original.
- Terry Reilly, its directors, officers, employees, agents and volunteers are hereby released from any legal responsibility or liability for disclosure or receipt of the above information to the extent indicated and authorized herein.
- **This authorization will expire one (1) year from the date of my signature, unless revoked prior to that date.**

_____ EXPIRES ONE YEAR FROM DATE SIGNED

Signature of Patient Date

If you are the Patient's Parent or Personal Representative and can legally act for the patient; please sign below. Patient capacity and your authority to sign as a Personal Representative will be verified.

_____ _____

Signature of Personal Representative, Guardian, or Parent of minor Date Relationship to Patient