

Authorization to Verbally Discuss Protected Health Information with Family and Friends

Patient Name _____ Date of Birth _____

Patient Address _____ City _____ State _____ Zip _____

Home/Cell Phone _____ Work
Phone _____

By signing this form, you authorize Greenway Surgical Suites' teammates to VERBALLY disclose information (e.g. via phone, face-to-face) to the individual(s) you list below. This is separate from your emergency contact(s) and separate from an Authorization for Release of Health Information.

Individual(s) Authorized to Receive Information Verbally:

Name: _____ Date of Birth (mm/dd/yyyy): _____ Relationship to Patient: <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Other: _____

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I authorize Greenway Surgical Suites to VERBALLY share my information with the family, friends or others that I have listed above as being involved in my health care or payment of my health care. The information to be released may consist of my past, present, or future health information including treatment and billing records.

This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocations must be sent in writing to: Greenway Surgical Suites, 2020 E 28th St, Suite 100 Minneapolis, MN 55407

Information used or disclosed due to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by state and federal law. To make changes or updates to this authorization, a new verbal disclosure authorization form must be completed and submitted to Greenway Surgical Suites.

The most current version of this form will be retained in the patient's medical record and honored by Greenway Surgical Suites and its teammates. This authorization will not expire unless revoked in writing by you or your legal representative.

All information below MUST be complete for this form to be valid:

Patient/Legal Representative
Signature: _____ **Date:** _____

Printed Name of Person Signing: _____

Relationship of Legal Representative to Patient (if applicable) _____