grand itasca® Clinic & Hospital | *Part of Fairview Health Services*

PERMISSION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION

Note: Completion of this form is optional. To be valid, this form must be filled out COMPLETELY, including what information you are giving us permission to share.

Patient Name: _____
Date of Birth: _____

I authorize to Grand Itasca Clinic & Hospital (GICH) caregivers and personnel to VERBALLY disclose the following medical and/or billing information regarding my health condition and care for the following purposes: (check all boxes that apply):

□ Scheduling/appointment information
□ Medical Information, including my symptoms, diagnosis, medications, and treatment plan.
This may also include information about sexually transmitted disease (STD) testing and treatment, HIV/AIDs testing and treatment, pregnancy testing, prenatal care, birth control and family planning.
Check Box to exclude this information □
□ Behavioral health information, including my symptoms, diagnosis, medications, and treatment plan
□ Chemical dependency information, including my symptoms, diagnosis, medications, and treatment plan
□ Lab/test results
□ Billing and payment information
□ Other: _____

GICH has my permission to discuss the above information with:

Name	Phone	Relationship to Patient

I understand that I may cancel this permission at any time (by writing to GICH Health Information), but that cancelling it will not affect any information that has already been released.

I understand that I do not have to sign this form, and that I should only sign it if I want my medical provider or other healthcare professional to share my information with someone.

I also understand that if I am unable to grant permission, information may be disclosed if, in the health care professional's judgment, it would be in my best interest.

This authorization expires:

□ When I cancel it in writing □_____ (*specify date*)

If no expiration date is specified, this authorization will remain in effect until GICH Medical Records receives written notice to cancel it.

□ I decline permission to verbally discuss medical information.

_____	_____	_____
Signature of patient/guardian	Date	Relationship to patient

_____	_____	_____
Witness is patient unable to sign	Date	Reason patient unable to sign

If authorized representative, please sign and attach copied of supporting legal documentation.

***Note: A minor patient's signature is REQUIRED for us to share information about care for (1) conditions relating to the minors sexuality including, but not limited to: family planning and sexually transmitted diseases (2) alcoholism and/or drug abuse; and (3) mental health conditions.**