



Release of Verbal Medical Information

Patient Name Date of Birth

The Oregon Clinic restricts the release of protected health information (PHI) to that permitted by patient confidentiality laws. According to HIPAA regulations, permitted reasons for release of PHI include treatment, payment and healthcare operations, or as otherwise allowed by the **specific signed authorization** of the patient or authorized personal representative.

The purpose of this Release of Verbal Medical Information form is to provide our patients an opportunity to permit verbal release of PHI in the following two (2) ways:

I. Permission to Verbally Discuss PHI with Family Members/Caregivers
I hereby authorize medical providers and personnel of The Oregon Clinic to discuss my protected health information with the following person(s):

Name/Phone number: Relationship:

Name/Phone number: Relationship:

Name/Phone number: Relationship:

-or- ☐ I decline. Please do not discuss my care with anyone other than as allowed by HIPAA regulations.

II. Permission to Leave a Detailed Message:
I hereby authorize medical providers and personnel of The Oregon Clinic to leave a detailed message at the following **phone number:** and/or **e-mail address:**

-or- ☐ I decline. Please do not leave me detailed messages.

Certain information cannot be released without specific authorization as required by state or federal law. By *initialing* the lines below, you authorize the release of the following protected or sensitive information:

Information regarding the patient's diagnosis and treatment of HIV/AIDS

Psychotherapy notes from a Psychiatrist or Psychotherapist

Treatment for alcohol or drug abuse reports

- This authorization will expire 730 days (2 years) from the date of signing.
- I understand that I have the right to revoke this authorization, in writing, at any time.
- I understand that such a revocation is not effective to the extent that the clinic has relied on the use or disclosure of the protected health information.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by state or federal law.
- This form is not valid unless signed and dated.

Signature of Patient/Personal Representative Name of Patient/Personal Representative

Date Description of Person Representative's Authority