Healdsburg Hospital
With Providence

Permission to Verbally Discuss Protected Health Information with Family and Friends

-Completion of this form is optional-

Patient name	Date of birth	Medical record number, if known	
Patient street address	City	State	ZIP
Home phone	Work phone		

I give permission for Healdsburg District Hospital ("Hospital") and the Clinics listed below ("Clinics") to VERBALLY share the information I have checked with the family, friends or others that I have identified below. *(check all boxes that apply)*
This form <u>does not authorize releasing copies of my records</u>.

- ☐ Scheduling/Appointment information
- ☐ Medical information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Behavioral health information, including my symptoms, diagnosis, medications and treatment plan
  - ☐ Substance use disorder
  - ☐ Developmental disability
- ☐ Lab/test results (☐ Check here to include HIV results)
- ☐ Billing and payment information
- ☐ Other (describe): _____

The Hospital and Clinics have my permission to discuss the above information with the following family, friends and other people. This information is directly relevant to their involvement in my health care (or payment for that care).

1 Name _____

Street address _____

City, State, Zip _____

Home phone _____ Work phone _____

2 Name _____

Street address _____

City, State, Zip _____

Home phone _____ Work phone _____

I understand that in certain situations the Hospital and Clinics may speak to other individuals who are involved in my care or payment of that care, if permitted by law that may not be identified on this form.

I understand that I have the right to revoke my permission at any time except where the Hospital and Clinics have already made disclosures in reliance upon this request. **I understand this permission remains in effect until the time I revoke it in writing.**

Signature of Patient/Authorized Representative X _____

If other than patient, state relationship and authority to sign _____

Date: _____

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Family and Friends – Information Sheet

We have established a process that allows you to tell us who we may talk with about your health care. This includes appointment and scheduling information, lab and test results, treatment information and billing information.

How can I give others permission to get verbal information about me?

Complete the Permission to Verbally Discuss Protected Health Information form on the reverse side of this page to let us know to whom we may speak about your information. Check the appropriate boxes to indicate what information we may discuss. You may also send us a letter with this information.

Does this mean that you will not speak to anyone I haven't specifically named on the form?

No. If permitted by law, Healdsburg District Hospital and its Clinics may speak to other individuals involved in your care (or payment for that care).

How is the information on the form used?

Anytime your designated person calls or makes a request on your behalf, we will verify the individual has your permission to receive the information and then we will share the information.

What are some examples of when this might be useful?

- If an individual wants to share information with spouse or significant other
- If an elderly parent wants an adult child to help understand medical treatment instructions
- If an adult child is helping with billing questions
- If a friend is helping a patient with health issues
- If a college student wants information shared with a parent
- If an adult child calls to find out his/her parent's appointment time

What if I change my mind?

You can change or revoke (stop) this process at any time by contacting us as follows:

US Mail: Healdsburg Hospital
Health Information Management Department
1375 University Ave, Healdsburg CA 95448

Fax: 707-431-6466

Email: 365-CA-HH-medrecrequests@providence.org

What happens if I don't complete this form?

We will continue to protect your private health information as required by law.

Can the person I designate also get copies of my medical records?

No, they can only receive verbal information. To get copies of medical records, complete a separate Authorization form available by contacting: Healdsburg District Hospital, Health Information Management Department, 1375 University Ave., Healdsburg CA 95448

Where do I send the completed form or any changes?

Please mail, fax or email this completed form or any changes to:

US Mail: Healdsburg Hospital
Health Information Management Department
1375 University Ave, Healdsburg CA 95448

Fax: 707-431-6466

Email: 365-CA-HH-medrecrequests@providence.org

HEALDSBURG HOSPITAL
Authorization to Verbally Disclose
Protected Health Information

Patient Label