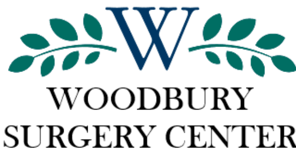

Authorization to Verbally Discuss Protected Health Information with Family and Friends

Patient Name____Date of Birth_____________________

Patient Address________________________________City___________________State____Zip__________

Home/Cell Phone_________________________________Work Phone______________________________

By signing this form, you authorize Woodbury Surgery Center 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: ☐ Parent ☐ Spouse ☐Child ☐ Sibling ☐Other:_______________________

Name:______________________________________Date of Birth (mm/dd/yyyy):_______________________

Relationship to Patient: ☐ Parent ☐ Spouse ☐Child ☐ Sibling ☐Other:_______________________

Name:______________________________________Date of Birth (mm/dd/yyyy):_______________________

Relationship to Patient: ☐ Parent ☐ Spouse ☐Child ☐ Sibling ☐Other:_______________________

I authorize Woodbury Surgery Center 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: Woodbury Surgery Center, Attn: Medical Records Dept, 587 Bielenberg Drive, Suite 100, Woodbury, MN 55125

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 Woodbury Surgery Center

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

<u>All information below MUST be complete for this form to be valid:</u>

Patient/Legal Representative Signature:_____________________________________**Date:**___________________

Printed Name of Person Signing:____

Relationship of Legal Representative to Patient (if applicable)___________________________________

INTERNAL – ROUTE FORM TO MEDICAL RECORDS