Duluth Family Medicine Clinic

Authorization to Verbally Discuss Protected Health Information

LABEL

Patient Address	City, State	Zip Code
Home Phone	**Work Phone**	**Date of Birth**

At my request, I give Duluth Family Medicine Clinic (DFMC) permission to *verbally* discuss the following medical and billing information about me (check all boxes that apply):

- ☐ **All Records**
- ☐ Scheduling/Appointment Information
- ☐ Medical Information, Including my symptoms, diagnosis, medications, and treatment plan
- ☐ Behavioral health information, including my symptoms, diagnosis, medications, and treatment plan
- ☐ Lab/test results
- ☐ HIV related information (AIDS related testing)
- ☐ Billing and payment information
- ☐ Other (describe): _____

Duluth Family Medicine Clinic has my permission to discuss the above information with:

- Name: _____Relationship:_____
  Address: _____
  City, State, Zip: _____
- Name: _____Relationship:_____
  Address: _____
  City, State, Zip: _____

- I understand the expiration ate of this authorization is _____ or 1 year from today's date, whichever is sooner.
- I understand that I have the right to revoke my permission at any time except where Duluth Family Medicine Clinic has already made disclosures in reliance upon this request. I understand I must notify DFMC in writing if I want to revoke my permission.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand this consent for release of alcohol and /or drug abuse information is subject to revocation at anytime except to the extent that the program or person, which is to make the disclosure, has already acted in reliance on it.
- I understand that Essentia Health may not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.
- I understand I will receive a copy of this form after I have signed it.
- I understand a photocopy or fax of this form is the same as the original
- I understand that: (1) my HIV test results may be released without my authorization to persons/organizations that have access under Wisconsin law; and that (2) a list of those person/organizations is available upon request.

X_____ **X**_____

Printed Patient Name **Signature (patient/parent of Minor or personal representative)**

Date: ____/____/_____ **X**_____ **Witness (Signature must be witnessed)**