300047

BAPTIST HEALTH
Department/Practice: _____

BH VERBAL RELEASE AUTHORIZATION [Authorization to Verbally Disclose Protected Health Information with Family Member(s) or Other Designated Person(s)]

I _____ hereby authorize _____
(Patient's Name – *please print*) (Department/Practice)

to verbally share the following information:

- ❑ Appointments
- ❑ Payments/Billing
- ❑ Diagnostic procedure results
- ❑ Prescription refills
- ❑ Culture results
- ❑ Lab results
- ❑ Plan of Care/Progress

with the individuals listed below who may be involved with my health care or payment for my health care:

Name:	Relationship to Patient:
_____	_____
_____	_____
_____	_____

❑ I authorize my provider or other staff in his/her practice/department to leave detailed messages regarding the above medical information on my answering machine/voicemail at:

- ❑ Home ❑ Cell/mobile
- ❑ All phone numbers listed

❑ I prefer that my provider or other staff in his/her practice/department speak with me personally regarding my medical information. Do not leave messages concerning my medical information.

I understand that I have the right to revoke this authorization at any time by written notification to _____;
(Department/Practice)
however, the revocation will not apply to information that already has been released in reliance upon this authorization. I also understand that this authorization is valid until further notice or written revocation by me. I understand that it is my responsibility to advise _____ of changes to my telephone numbers or my preferences regarding
(Department/Practice)
telephone messages. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits. I understand and acknowledge that the confidential health care information disclosed to the above named individuals may be subject to re-disclosure by those individuals and may no longer be protected by federal privacy regulations. The provider expressly reserves the right to disclose information to others who may not be on the list if and to the extent allowed by HIPAA, including but not limited to disclosures for treatment, payment, or healthcare operations.

_____ _____
Patient's Signature (parent/guardian if patient is a minor) Date