|  |
| --- |
| Patient Name (First, Middle, Last) |
| Birth Date (mm-dd-yyyy) |

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Description automatically generated

**Authorization to Verbally Disclose**

**Protected Health and Billing Information to Family and Friends**

**Instructions:** Please read carefully and complete the form.

Simplicity Health values your privacy, and we want to protect it as much as possible. By signing this **you authorize Simplicity Health to disclose information verbally** (via phone or 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** (First, Middle, Last) |
| Relationship to Patient: |
| **Name** (First, Middle, Last) |
| Relationship to Patient: |
| **Name** (First, Middle, Last) |
| Relationship to Patient: |

I understand this authorization applies to all Simplicity Health locations. This information to be released may consist of my past, present, or future health information including treatment and billing records. **These records may contain information related to behavioral/mental health care, substance abuse treatment, HIV/AIDS, and genetics.** This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing and sent to Health Information Management.

Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by state and federal law. If I want to change/update individuals who can receive verbal information, I must submit a new Authorization to Verbally Disclose Protected Health and Billing information form. Simplicity will honor the most current version of this form retained in the electronic medical record.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient/Legal Representative Signature (required)** | | | | Date (required) (mm-dd-yyy) |
| Print Name of Person Signing (If not patient) (First, Middle, Last) | | | | |
| Relationship of Legal Representative to Patient (if applicable) | | | | |
| Patient Street Address | | | | |
| City | State | Zip Code | Phone | |

**Send form to:**

Simplicity Health

3260 42nd Ave South

Saint Cloud MN 56301

Fax: 320-227-2025

Email: info@simplicityhealthmn.com