Place Patient Label Here

ROCKWOOD

Authorization for Verbal Communications

Patient Information

Name – First /MI/Last (Please print)		
Street Address		
City	State	Zip
Date of Birth	Phone Number	

I, ____, __________________, authorize Rockwood Clinic, their
(Name: Please Print) (Date)

physicians, nurses, and other personnel ("health care providers") to discuss health information, in person or by telephone, with the following **family members or friends directly involved in my medical care**.

Name **(Please print)** **Phone Number** **Relationship**

1) ____

2) ____

I UNDERSTAND THAT THIS COMMUNICATION:

- **May include information on diagnosis/treatment related to psychiatric or psychological conditions, drug and/or alcohol abuse, pregnancy, sexually transmitted diseases (STD) acquired immune deficiency syndrome (AIDS), and/or HIV status and/or other "sensitive information."**

I UNDERSTAND THAT THIS AUTHORIZATION IS:

- **Limited** to verbal and telephone conversations and **does not permit** or authorize the release of any **written health information** to any of the individuals named above.
- **Limited** to the specific timeframe determined by me and that **if I do not specify a specific timeframe,** this authorization will **remain in effect for an unlimited amount of time.**

I further understand that if, I do not want verbal discussions to be permitted between my health care provider and any of the individuals named above I have the right to revoke this authorization, in writing, at any time. I understand that this written revocation will **not** affect any disclosures of my medical information that the person(s) and/or organization(s) listed on this authorization that have already made, in reliance on this authorization, before the time I revoke it.

This document has been explained to me and all of my questions have been answered satisfactorily.

____ _______/________/_______
(Signature of patient or legal representative) (Date)

____
(Relationship to patient)

This authorization is NOT valid unless it is signed and dated by the patient or their representative

Who May Sign This Authorization:

1. Generally, all patients 18 years of age or older must sign for communication of their own health information unless the following conditions apply:
    - The patient is incompetent
    - The patient is disabled an cannot sign the form

2. All persons signing for communication of health information on behalf of the patient must state their relationship to the patient and provide proof of legal authority of their capacity to act for the patient

3. Minors: Patients under 18 years of age must sign for communication of their health information in the following cases:
    - Alcohol or other drug abuse : age 13 or older
    - Mental health: age 13 or older
    - Sexually transmitted disease: age 14 or older
    - Any age for reproductive health

Release of Information under this document is limited to **VERBAL** discussions only. This authorization does not authorize release of written information or **copies** of medical records to the individuals listed. **– Use the Rockwood Clinic Authorization for the Use, Disclosure or Release of Information form**.

To revoke this authorization you must notify your health care provider by contacting **Rockwood Clinic's Health Information Management** department and complete a written document revoking this authorization.