Permission to Verbally Discuss Protected Health Information

-Completion of this form is optional-

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #:_____

Verbal Communication:

I give permission to Horizon Health to **VERBALLY** discuss the following medical and billing information about me (check all boxes that apply):

- ☐ Scheduling/Appointment information
- ☐ Medical information, including symptoms, diagnosis, medications and treatment plan
- ☐ Lab test results or x-rays
- ☐ Billing and payment information
- ☐ Horizon Health employee - Leave of Absence (specify): _____
- ☐ Other (describe): _____

I give permission to Horizon Health to **VERBALLY** discuss the following health and billing information medical and billing information about me – initial where release is approved:

_____Mental health treatment information, including my symptoms, diagnosis, medications and treatment plan

_____ Sensitive health information for conditions of sexually transmitted diseases, HIV/AIDS, and sexual assault treatment

_____ Chemical dependency information containing drug and alcohol treatment, including my symptoms, diagnosis, medications and treatment plan

_____ Genetic information

_____Immunization Records

Horizon Health has my permission to discuss the above information with:

_____	_____	_____
First name, last name	Relationship to me	Best contact number
_____	_____	_____
First name, last name	Relationship to me	Best contact number
_____	_____	_____
First name, last name	Relationship to me	Best contact number

Continued on back

- I understand that I may revoke this authorization, in writing, at any time except to the extent that Horizon Health has already relied on this authorization.

- I understand that I may revoke this authorization by sending or faxing a written notice to _____

- I understand that Horizon Health may not condition treatment, payment/enrollment or eligibility for benefits on the completion of this authorization form.

- I understand that information being disclosed may be subject to re-disclosure by the recipient and may no longer be protected.

Unless otherwise revoked, this Authorization shalt be in force and effect indefinitely.

By signing below, I agree that I have reviewed and I understand this authorization.

By: _____ Date: _____
Patient Signature

Please attach a copy of your government issued photo identification with your signature (driver's license)

OR

By: _____ Date: _____
Patient Representative

Relationship to patient: ☐ Legal guardian* ☐ Holder of Power of Attorney* ☐ Parent of minor child

Please attach proof of identification and legal documentation if you are the legal guardian or Holder of Power of Attorney

Please attach a copy of your government issued photo identification with your signature (driver's license)

Office Use Only:

Date entered in EMR: _____

Initials: _____