Verbal Authorization to Disclose Healthcare Information

LOGAN HEALTH

Name _____

Street Address _____ City _____ State _____ Zip _____

Date of Birth _____ Phone Number _____

I authorize Logan Health, their physicians, nurses, and other personnel to discuss the health information listed below in person or by telephone:

☐ Appointment Information ☐ Billing Information ☐ Medical/Clinical Information

With the following individuals **directly involved in my medical care.**

	Name (Please print)	Phone Number	Relationship
1)			
2)			
3)			
4)			

If you have elected to share medical/clinical information please note below if any of these specific items should be **excluded** from what we share. If you have not elected to share medical/clinical information please skip the section contained in the box below:

Do not discuss the following from medical/clinical information:

Visits with Dates of Service between _____ - _____ or the following medical conditions:

☐ HIV (AIDS virus) ☐ Sexually transmitted diseases ☐ Genetic information and indicators

☐ Psychiatric/mental health conditions ☐ Substance use disorder ☐ Cancer

Other medical conditions not to disclose: _____

I UNDERSTAND 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.

Once Logan Health discloses your health information, the recipient may re-disclose the information, and privacy laws may no longer protect your information. Federal and state laws may forbid sharing information about substance use disorders, sexually transmitted diseases, or mental health information without written consent of the patient.

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 have already made, in reliance on this authorization, before the time I revoke it.

Logan Health will not condition treatment, payment, enrollment or benefit eligibility on my signing this document. This document has been explained to me and all of my questions have been answered satisfactorily.

This Authorization expires in 30 months (unless a lesser date or event is specified): Date/Event: _____

_____ _____ * Legal Authority: _____

Signature of Patient/Representative Date *If signed by person other than the patient, print name and identify relationship.

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 patient lacks capacity.
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.

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 Logan Health Authorization to Disclose Health Information** form for copies of records.

REVOCATION OF AUTHORIZATION

You may revoke this authorization in writing. You may call one of the departments listed or obtain the hospital address under Health Information Management (Medical Records) on https://www.Logan.org/krhc/services/medical-records.

The revocation will be effective upon receipt, but will not apply to information that has already been released or to services already provided according to this consent.

Logan Health Medical Records (406) 752-1740 Logan Health Corporate Compliance 833-594-032