TAHOE FOREST HEALTH SYSTEM

Authorization for Verbal Communication of Protected Health Information

Patient Name: (Please print)_____ **DOB**:_____

Medical Record # (office staff use) _____

My signature below indicates my agreement to the following (check each applicable item):

- ☐ Multiple providers in the Tahoe Forest Multispecialty Clinics treat me. This form applies to all of those providers.
- ☐ This form applies only to:_____ (provider name)

Protected Health Information: **Please indicate with whom we may discuss your Protected Health Information (i.e. spouse, partner, child, parent, friend, etc.):**

- ☐ None, discuss only with me.
- ☐ You may discuss my Protected Health Information with the following person(s):
  1. Name: _____ Relationship:_____
  2. Name: _____ Relationship:_____
  3. Name: _____ Relationship:_____
  4. Name: _____ Relationship:_____

  - ☐ I want this Authorization to end on (specific date):_____
  - ☐ **There is no end date**.

Insurance/Billing Information: Please indicate with whom we may discuss insurance and billing matters (i.e. spouse, partner, child, parent, friend, etc.):

- ☐ None, discuss only with me.
- ☐ You may discuss my Protected Health Information with the following person(s): Write "Same" if same as above.
  1. Name: _____ Relationship:_____
  2. Name: _____ Relationship:_____
  3. Name: _____ Relationship:_____
  4. Name: _____ Relationship:_____

  - ☐ I want this Authorization to end on (date):_____
  - ☐ **There is no end date**

**Please note that the provisions of your insurance policy, and applicable regulations, may permit us to discuss insurance/billing information with persons not indicated here.*

Signature of Patient or Authorized Representative: _____

Print Name: _____ Date: _____

Relationship: _____