



**AUTHORIZATION TO VERBALLY RELEASE
INFORMATION FROM PHYSICIAN OFFICE**

Patient name:

Date of birth:

Attending physician:

I understand that my personal healthcare information is protected under the Health Insurance Portability and Accountability Act (HIPAA). I authorize Christiana Care to VERBALLY disclose the information I have marked to the individuals identified below.

Name	Relationship	Contact Phone Number

<input type="checkbox"/> Scheduling/Appointment information	<input type="checkbox"/> Billing and payment information/ Financial status	<input type="checkbox"/> Medical information (i.e.; diagnoses, medications, immunizations, treatment plans)
<input type="checkbox"/> General test results (i.e. lab, x-ray, MRI, pathology)	<input type="checkbox"/> Sensitive test results (i.e.; STD, HIV, Cancer, OB/GYN)	<input type="checkbox"/> Behavioral Health conditions

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<input type="checkbox"/> General test results (i.e. lab, x-ray, MRI, pathology)	<input type="checkbox"/> Sensitive test results (i.e.; STD, HIV, Cancer, OB/GYN)	<input type="checkbox"/> Behavioral Health conditions

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<input type="checkbox"/> Scheduling/Appointment information	<input type="checkbox"/> Billing and payment information/ Financial status	<input checked="" type="checkbox"/> Medical information (i.e.; diagnoses, medications, immunizations, treatment plans)
<input type="checkbox"/> General test results (i.e. lab, x-ray, MRI, pathology)	<input type="checkbox"/> Sensitive test results (i.e.; STD, HIV, Cancer, OB/GYN)	<input type="checkbox"/> Behavioral Health conditions

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Expiration and Revocation:

This authorization expires one year from the date it is signed. I understand this authorization may be revoked at any time but is not retroactive for information that has been shared in good faith and prior to this authorization being revoked. To revoke this authorization, I understand that I must provide a written request to the office releasing my information.

Christiana Care will not condition treatment, payment, enrollment or eligibility for benefits on the completion of this authorization. Once released, the information may no longer be protected by Federal Privacy Rules and may be subject to redisclosure by the recipient. However, information covered under Federal Regulations 42 CFR Part 2 may not be redisclosed unless expressly permitted by the authorization or the regulations.

In addition to the disclosure authorized by this form, I understand that Christiana Care will use and disclose my information for treatment, payment, and healthcare operations, and as allowed by applicable law and as stated in the Notice of Privacy Practices.

_____/_____/_____
Signature of Patient or Decision Maker Relationship to Patient Date Time

_____/_____/_____
Witness Signature Witness Print Name Date Time

Interpretation: The information has been presented to the: patient representative decision maker in: _____
The person who provided the interpretation is a qualified medical interpreter. Language

Interpreter Name Agency and ID# (if applicable)

_____/_____/_____
Witness Signature Print Name Date Time

Key: CFR - Code of Federal Regulations HIV - Human Immunodeficiency Virus MRI - Magnetic Resonance Imaging OB/GYN - Obstetrics/Gynecology
STD - Sexually Transmitted Disease