Patient name (Last, First, MI)	Date of birth	Medical record #	
Patient street address	City	State	Zip
Home phone	Work phone		

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

☐ Scheduling/Appointment information
☐ Medical information, including my symptoms, diagnosis, medications, and treatment plan
☐ Behavioral health information, including my symptoms, diagnosis, medications, and treatment plan
☐ Substance Use Disorder information
☐ Lab/test results
☐ HIV related information (AIDS related testing)
☐ Billing and payment information including ClearBalance Account Authorization
☐ Other (describe): _____

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

1 Name _____ Relationship: _____
Street address _____
City, State Zip _____
Home phone _____ Work phone _____

2 Name _____ Relationship: _____
Street address _____
City, State Zip _____
Home phone _____ Work phone _____

- I understand the expiration date of this authorization is _____ or 1 year from today's date, whichever is sooner.
- I understand that I have the right to revoke my permission at any time except where Essentia Health has already made disclosures in reliance upon this request. I understand I must notify Essentia Health in writing if I want to revoke my permission.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal Privacy regulations 42 CFR Part 2; HIPAA.
- I understand psychotherapy and SUD counseling notes will not be released per facility; HIPAA Privacy Rules 45 CFR 160, 164, 164.502; and 42 CFR 2.11, 2.31(b).
- I understand that Essentia Health may not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.
- I understand, that upon my request, I may receive a copy of this form after I have signed it.
- I understand a photocopy or fax of this form is the same as the original.
- I understand that: (1) my HIV test results may be released without my authorization to persons/organizations that have access under Wisconsin law; and that (2) a list of those persons/organizations is available upon request.

Where do I send the completed form or any changes?

Essentia Health – HIM
502 East Second Street
Duluth MN 55805
Fax: 218-786-1370
Email: SendMyMedicalRecordstoHIM@essentiahealth.org

x _____ _____/_____/_____ _____

Signature (patient/parent of Minor or personal representative) | Date | Witness (only required if patient signature is made by mark)

Essentia Health

AUT001

Authorization to Verbally Discuss
Protected Health Information

Essentia Health knows that privacy regulations have an impact on our customer service to you, especially when it comes to discussing information about you with family, friends, and others you designate who are involved in your care. By completing the Authorization to Verbally Discuss Protected Health Information form, it will allow us to talk about your medical care to those you have designated. This includes appointment and scheduling information, lab and test results, treatment information, and billing information.

How can I give others permission to get verbal information about me?
Complete the Authorization to Verbally Discuss Protected Health Information form to let us know to whom we may speak about your information. Check the appropriate boxes to indicate what information we may discuss.

How is the information on the form used?
Any time your designated person calls or makes a request on your behalf, we will verify the individual has your permission to receive the information and then we will share the information.

What are some examples of when this might be useful?

- If an elderly parent wants an adult child to help understand medical treatment instructions.
- If an adult child is helping with billing questions.
- If a friend is helping an elderly patient with health issues.
- If a college student wants information shared with a parent.
- If an adult child calls to find out his/her parent's appointment time.

Can the person I designate also get copies of my medical records?
No, they can only receive verbal information. To get copies of medical records, you must complete a separate Authorization for Use and Disclosure form available at your treating facility.

What if I change my mind?
You can change or revoke (stop) this process at any time by notifying us in writing at the address below. This authorization must be renewed annually.

What happens if I don't complete this form?
We will continue to protect your private health information as required by law. Completion of this form is optional.