



**Authorization to Verbally Release Health Information**

Due to the Health Insurance Portability Accountability Act

I, name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_\_, authorize *CHPG Health Care Providers and Staff* to verbally release/discuss any and all health/medical information to:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_ Contact #: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_ Contact #: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_ Contact #: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_ Contact #: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_ Contact #: \_\_\_\_\_

I understand that the information I have agreed to release to the aforementioned party may include sensitive clinical information obtained. These may or may not include treatment of substance or other abuse, HIV, psychiatric disorders, sexually-transmitted diseases, etc., unless herein excepted.

I choose to have this authorization expire:

- no expiration date
- 1 year
- following event or condition(ie. Hospitalization): Specify: \_\_\_\_\_

I understand that I can revoke, update or change this form at any time in writing. The termination of this authorization to release Protected Healthcare information is effective on the date that the physician office receives it. It does not apply to any information released prior to the date of receipt of the written termination.

**Signature:** \_\_\_\_\_ **Date of Signature:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_