



PATIENT
LABEL

AUTHORIZATION TO VERBALLY DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

The Portland Clinic, LLP is authorized to verbally disclose protected health information (PHI) according to HIPAA regulations. Permitted reasons for release of PHI include treatment, payment and healthcare operations, or as otherwise allowed by specific signed authorization by the patient or authorized personal representative.

I hereby authorize verbal disclosure of the named individual's health information:

Patient Name	Date of Birth	Telephone Number
Address (Street, City, State, ZIP Code)		
Permission to Verbally Discuss Protected Health Information with Family Members/Caregivers		
Name: _____	Relationship: _____	Telephone: _____
Name: _____	Relationship: _____	Telephone: _____
Name: _____	Relationship: _____	Telephone: _____
-or- <input type="checkbox"/> I Decline. Please do not discuss my care with anyone other than allowed by HIPAA regulations.		
I understand that certain information cannot be released without specific authorization as required by State/Federal law. By initialing below, you authorize the release of the following protected or sensitive information.		
_____ Alcohol and Substance Abuse	_____ Mental Healthcare	_____ HIV and Sexually Transmitted Diseases
<ul style="list-style-type: none"> Unless otherwise revoked, this authorization will expire on the following date: _____ If I do not specify an expiration date, this authorization will expire in two years. I understand I have the right to revoke this authorization. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by state or federal law. This form is not valid unless signed or dated. 		
Signature of Patient or Legal Representative		Date
If signed by Legal Representative, Relationship to Patient		