The Portland Clinic

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)

1. Permission to Verbally Discuss Protected Health Information with Family Members/Caregivers

Name: _____ Relationship: _____ Telephone: _____

Name: _____ Relationship: _____ Telephone: _____

Name: _____ Relationship: _____ Telephone: _____

-or- ☐ **I Decline.** Please do not discuss my care with anyone other than allowed by HIPAA regulations.

2. Permission to Leave a Detailed Message

I authorize medical providers and personnel of The Portland Clinic to leave a detailed message by the following methods.

Phone number_____ and/or Email address_____

-or- ☐ **I Decline.** Please do not leave me detailed messages.

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

- If I do not specify an expiration date below, **this authorization will expire in 2 years from the date of signing**. Unless otherwise revoked, this authorization will expire on the following date: _____/_____/_____
- 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