Mid-Valley Hospital & Clinic
810 Jasmine St. Omak, WA 98841 | 509-826-1760 | fax: 509-826-7211

Permission to Verbally Discuss Protected Health Information with Family and/or Friends

NOT VALID WITHOUT **copy of photo ID*

Patient Information
Patient Name (Last, First, MI): _____

Former Name(s) / Alias: _____ Date of Birth: _____

Phone Number: _____ Address, City, State, Zip: _____

Mid-Valley Hospital and Clinic has my permission to discuss my health information as described below with the following family member, friend, or other person. List only 1 person on each form. This information is directly relevant to their involvement in my health care (or payment for that care). I understand that this form does NOT authorize releasing copies of my medical records.

Person Named: _____ Phone Number: _____

Address, City State, Zip: _____

I give permission for Mid-Valley Hospital and Clinic to VERBALLY share the information I have checked below with family, friends, or other person I have identified above as being involved in my health care, care coordination or payment of my health care (check all boxes that apply).

__ Scheduling / Appointment Information __ Billing and Payment Information

__ Medical Information including my symptoms, diagnosis, medications and treatment plan

__ *Sensitive Information:* By checking this box, I authorize discussion about sensitive information which may include sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), mental health or reproductive health.

__ SUD info (alcohol/drug use treatment). *Checking SUD authorizes release of info protected by 42 CFR Part 2*

__ Other (describe): _____

Purpose of Disclosure (Required)
__ Care coordination __ Payment/Billing __ Legal/Family involvement ___ Other: _____

Expiration of Authorization (Required)
__ On (date):_____ __ Upon this event/condition;_____
__ One year from date of signature

I understand that in certain situations Mid-Valley Hospital and Clinic personnel may speak to other individuals who are involved in my care or payment of that care, if permitted by law, that may not be identified on this form. I understand that I have the right to revoke my permission at any time except where Mid-Valley Hospital and Clinic has already made the disclosures in reliance upon this request. If an updated *Permission to Verbally Discuss Protected Health Information with Family and Friends* form is received, the new version will replace any previous versions on file**. I understand that this form does NOT authorize releasing copies of my medical records.**

Signature of Patient / Authorized Representative: _____ Date: _____
If other than patient, state the relationship & authority to sign (provide documentation): _____