Patient Authorization to: Discuss Health Information (Verbal) with Friends and Family and/or Leave Care-Related Messages on a Messaging System

Place Patient Label Here

This authorization is limited to VERBAL discussions/messages. No paper copies or electronic access will be provided using this authorization.

Patient Name ____________ **Date of Birth** ____________ MRN (Medical Record Number) ____________

Please review entire form and check the boxes to indicate your preferences.

I authorize Samaritan Heath Services (SHS) to *VERBALLY* discuss health information relevant to my care or payment of that care with family and/or friends (as specified below) and/or *leave detailed messages* containing specific medical information on a messaging system regarding the following information:

Consent to leave message:

If unable to reach me:

- ☐ you may leave a detailed message
- ☐ leave a message asking me to return your call
- ☐ Other: ____________

The best time to reach me is (day)____________ between (time)____________

I do not want the following health information to be left on a message:

☐ HIV Test Results ☐ Genetic Testing ☐ Mental Health Specific Visits ☐ Drug/ Alcohol Specific Visits

☐ Other: ____________

Individuals authorized to discuss information related to my health care:

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information.

I do not want the following health information to be shared:

☐ HIV Test Results ☐ Genetic Testing ☐ Mental Health Specific Visits ☐ Drug/ Alcohol Specific Visits

☐ Other:____________

Information may be released to:

Name (first and last):	Phone number:	Relationship to patient:
Name (first and last):	Phone number:	Relationship to patient:
Name (first and last):	Phone number:	Relationship to patient:

☐ Information is not to be released to anyone.

- **I understand the instructions and information on page 1 and 2 of this authorization.** Unless canceled (revoked), this authorization expires on ____________ (date or event) or 365 days from the date I signed this form. If preferred, you may specify 'NONE' (no expiration date).

Signature of Patient or Patient Representative ____________ Relationship to Patient ____________ **Date signed** ____________

Print Name of Signature ____________

This box is to be completed by SHS ONLY

Date Received: ____________ ☐ **ID Verified**

Staff reviewed for completeness - Initials: ____________

INSTRUCTIONS for COMPLETING THE AUTHORIZATION

For this authorization to be valid all sections must be complete, signed, and dated by me or on my behalf by a personal representative.

Treatment and/or reimbursement for services may not be withheld or conditioned on obtaining this authorization. I may refuse to sign this authorization.

I understand that I have the right to a copy of this authorization form.

DISCLOSURE:
This authorization is limited to VERBAL discussions/messages. No paper copies or electronic access to my health information will be provided to the persons above without specific authorization on an SHS Patient Authorization to Disclose Health Information or other equivalent authorization.

SIGNATURE: The patient's signature is required. If the patient is incapable of signing the authorization, a personal representative such as the parent or legal guardian of a minor, or someone designated in a health care power of attorney or advance directive of the patient may sign on the patient's behalf. Legal documentation showing the authority to act for the patient may be required, prior to the request for medical records being processed. Examples of acceptable documentation include: Health Care Power of Attorney, Death Certificate, or Court Order.

OTHER IMPORTANT INFORMATION:

CANCELLATION/ REVOCATION: I may revoke (cancel) this authorization in writing at any time. The written request does not apply to information that has already been released in accordance to this authorization. To cancel this authorization it must be in writing and signed by me or on my behalf by a personal representative. I must send a copy of this authorization and my written statement revoking this authorization to Samaritan Health Services, Health Information Management (HIM) Department, PO Box 2728, Corvallis, OR 97333.

Notice of Privacy Practices
I understand Samaritan Health Services (SHS) protects all health care information. These protections and my patient rights regarding my health care information are outlined in the SHS Notice of Privacy Practices available at www.samhealth.org.

MINORS: In the state of Oregon, minors may be able to request certain levels of confidentiality or consent to various health care matters depending on their age without parental consent. When a minor presents for treatment as described above, it is Samaritan Health Services policy to require the minor to authorize disclosure of their health information. (Reference; ORS 109.675, 109.610, 109.640)

Contact Information

PLEASE RETURN YOUR AUTHORIZATION FORM(S) TO:

Department:
Address:

Phone:
Fax: