



Permission to **Verbally** Discuss

Protected Health Information with Family and Friends

—Completion of this form is optional—

Patient name	Date of birth	Medical record number, if known	
Patient street address	City	State	ZIP
Home phone	Work phone		

I give permission for the Cogdell Family Clinic to **VERBALLY** share the information I have checked with the family, friends or others that I have identified below as being involved in my health care, care coordination or payment of my health care. (check all boxes that apply) This form does not authorize releasing copies of my records.

- Scheduling/Appointment information
- Medical information, including my symptoms, diagnosis, medications and treatment plan
- Behavioral health information, including my symptoms, diagnosis, medications and treatment plan
 - Substance use disorder
 - Developmental disability
- Lab/test results (Check here to include HIV results)
- Billing and payment information
- Other (describe): _____

The Cogdell Family Clinic has my permission to discuss the above information with the following family member, friend or other person. This information is directly relevant to their involvement in my health care (or payment for that care).

Name _____

Street address _____

City, State, Zip _____

Home phone _____ Work phone _____

Name _____

Street address _____

City, State, Zip _____

Home phone _____ Work phone _____

I understand that in certain situations the Cogdell Family Clinic 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 Cogdell Family Clinic has already made disclosures in reliance upon this request. I **understand this permission remains in effect until the time I revoke it in writing**. If an updated PERMISSION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION WITH FAMILY AND FRIENDS form is received and it has an identical family member/friend/other person listed with updated permissions (different checkboxes), the new version will automatically revoke the previous version on file.

Signature of Patient/Authorized Representative **X** _____ Date _____

If other than patient, state relationship and authority to sign _____

NOTE: For copies of medical records, contact Health Information Management at 325-574-6922 or Medicalrecords@Cogdellhospital.com.

Permission to Verbally Discuss Protected Health Information with Family and Friends – Information Sheet

We have established a process that allows you to tell us who we may talk with about your health care. This includes appointment and scheduling information, lab and test results, treatment information and billing information.

Where do I send the completed form or any changes?

Please send or fax the completed form to your Primary Care Nurse.

Note: If you need to obtain copies of your health records, contact Health Information Management at (325)574-6922 or Fax Request to (325)574-7389. You can also email Health Information Management at MedicalRecords@cogdellhospital.com.

How can I give others permission to get verbal information about me?

Complete the Permission to Verbally Discuss Protected Health Information form on the reverse side of this page to let us know to whom we may speak about your information. Check the appropriate boxes to indicate what information we may discuss. You may also send us a letter with this information.

Does this mean that you will not speak to anyone I haven't specifically named on the form?

No. If permitted by law, Cogdell Family Clinic may speak to other individuals involved in your care (or payment for that care).

How is the information on the form used?

Anytime your designated person calls or makes a request on your behalf, we will verify the individual has your permission to receive the information and then we will share the information.

What are some examples of when this might be useful?

- If an individual wants to share information with spouse or significant other
- If an elderly parent wants an adult child to help understand medical treatment instructions
- If an adult child is helping with billing questions
- If a friend is helping a patient with health issues
- If a college student wants information shared with a parent
- If an adult child calls to find out his/her parent's appointment time

What if I change my mind?

You can change or revoke (stop) this process at any time by writing to us at the address shown above. Forms are available at your clinic [Of note: If an updated PERMISSION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION WITH FAMILY AND FRIENDS form is received and it has identical family member/friend/other people listed with updated permissions (different checkboxes), the new version will automatically revoke the previous version on file.]

What happens if I don't complete this form?

We will continue to protect your private health information as required by law.

Can the person I designate also get copies of my medical records?

No, they can only receive verbal information. To get copies of medical records, complete a separate Authorization form available by contacting Health Information Management at (325)574-6922 or Medicalrecords@cogdellhospital.com

Clinic Use ONLY

- Scan In Patient's Chart
- Use Type: HIPAA Privacy/Disclosure Documents
- Change the Date to the Signature Date on Form
- Subject: Date of Signature Cogdell Clinic Verbal Consent
 - Example: 05/22/2023 Cogdell Verbal Consent
- **Check the Patient Level Document**