Patient Name: _____

Medical Record Number: _____

Date of Birth: _____

GUNDERSEN HEALTH SYSTEM®

AUTHORIZATION FOR VERBAL COMMUNICATION OF HEALTH INFORMATION

With the implementation of the Health Insurance Portability and Accountability Act (HIPAA), Gundersen Clinic, Ltd., Gundersen Lutheran Medical Center, Inc., Gundersen Boscobel Area Hospital and Clinics, Gundersen Palmer Lutheran Hospital and Clinics, Gundersen St. Joseph's Hospital and Clinics, Gundersen Tri-County Hospital and Clinics, and Gundersen Moundview Hospital and Clinics (collectively "Gundersen") must have your specific authorization to share any of your Protected Health Information (PHI) with a spouse or family member or to leave a message regarding your health care on you telephone answering machine. This is especially helpful if you are on medications that require frequent testing and adjustment, in case there is an urgent need to contact you if we need to reschedule an appointment, test or procedure and you are not available when we call or if there is someone who assists with your finances.

The type of information disclosed: medical history of diagnostic and therapeutic information, this may include information regarding mental health, developmental disability, HIV, and alcohol and drug abuse, unless otherwise specified below. This form **DOES NOT** authorize the disclosure of any of your written health information.

Section A

Verbal Communication Regarding My Treatment or Billing Can Be Shared With (please print):

1. Name _____ Relationship _____

   Phone _____ Home / Work / Cell Phone _____ Home / Work / Cell

   Type of information: ☐ All ☐ Behavioral Health ☐ Limited to:

2. Name _____ Relationship _____

   Phone _____ Home / Work / Cell Phone _____ Home / Work / Cell

   Type of information: ☐ All ☐ Behavioral Health ☐ Limited to: _____

3. Name _____ Relationship _____

   Phone _____ Home / Work / Cell Phone _____ Home / Work / Cell

   Type of information: ☐ All ☐ Behavioral Health ☐ Limited to: _____

Section B

Please indicate below where we may contact you and leave a detailed message regarding your Medical, Behavioral Health and/or Billing information, if appropriate:

Home: _____ **Work:** _____ **Cell:** _____

Section C

You may refuse to sign this authorization with the understanding that this may result in a delay of treatment and/or potentially adverse health consequences. By signing this form, you understand that at any time, you may change or revoke this authorization in writing. This authorization will expire in two years from the date signed or upon completion of a new form.

_____ _____

Signature of Patient Date

_____

(If signed by authorized person, state relationship and authority to do so.)