Verbal Communication Authorization Form

PATIENT INFORMATION			
Last Name	**First Name**	**MI**	**Date of Birth**

Would you like to revoke a previous verbal authorization? If yes, list those who should no longer have access here:

_____

SHARING OF HEALTH INFORMATION

Would you like to allow GVHC staff to speak with anyone other than yourself about your care?

*If **YES,** name your trusted person(s) in the table below, and set their level of access to your personal health information (PHI).*

Full Name	**Phone #**	**Relationship**	**Level 1:** Medical & dental treatment & PHI	**Level 2:** Appointments & scheduling	**Level 3:** Limited PHI, **specifically**	**Level 4:** Behavioral Health PHI

Unless otherwise revoked, this authorization will expire 30 months {2.5 years) after it is created. You may revoke this authorization in writing at any time. Once released to another individual, your personal health information is no longer protected under federal law, and may be re-disclosed by the recipient.

_____ _____

Patient or parent/legal guardian signature **Date**

_____ _____

If signed by parent/legal guardian, please print name Relationship to patient

_____ _____

GVHC Employee/Witness Signature GVHC Employee/Witness Signature

Expiration date:_____