Patient Chart Identification

PERMISSION FOR VERBAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE AND SIGN

The Health Insurance Portability and Accountability Act (HIPAA) requires NWHS to obtain your authorization to allow verbal communications regarding your protected health information. This authorization allows NWHS to:

- Leave recorded messages at your home, work, or on your cell phone related to your health care and treatment, payment, or appointment status
- Discuss your health care with a spouse, child, friend, or other person that you designate.

I. PATIEN/CLIENT INFORMATION

PATIENT/CLIENT NAME: | DATE OF BIRTH:

II. TELEPHONE COMMUNICATION PREFERENCES

Do we have your permission to:

Leave a message on your **cellular phone**? ☐ Yes, at #_____ ☐ No ☐ Do not have one

Leave a message on your answering machine at **home**? ☐ Yes, at #_____ ☐ No ☐ Do not have one

Leave a message at your place of **employment**? ☐ Yes, at #_____ ☐ No ☐ Do not have one

Discuss your health care with other members of your family or friends? ☐ Yes** ☐ No

***If YES, please list in the section below the name(s) of the person(s) and their relationship to you.*

III VERBAL COMMUNICATION OF PROTECTED HEALTH INFORMATION WITH OTHERS

I permit NWHS, their providers, nurses, and other personnel to discuss health information in person or by telephone with the following family members, friends or other individuals involved in my health care:

(List family members/friends and state the person's relationship to the patient/client. If no person is permitted to receive your protected health information, please write the word NONE, in the section below).

Name:	*Relationship:*	*Phone Number:*
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any health information that you would like to be kept confidential from any person(s)? If so, please specifically describe the information and person(s) below:

_____

_____

(If no limitations are listed above, discussions will be permitted regarding all aspects of my health care with those individuals listed in the previous section).

IV PATIENT/CLIENT ACKNOWLEDGEMENT AND SIGNATURE

This permission may be revoked in writing at any time. To revoke this permission, please send a written statement to the Privacy Officer, Northwest Human Services, 1233 Edgewater St NW, Salem, Oregon 97304, and state that you are revoking this permission. Unless revoked earlier, this permission will expire on the following date, event, or condition. If no expiration date, event, or condition was specified, this authorization will expire 1 year from the date of signing.

_____
(Date, event, or condition)

This signature does not authorize the release or disclosure of any of my written protected health information. I have read this authorization and I understand it.

_____ (Date) | _____ (Signature of Patient/Client or Personal Representative) | _____ (Description of Personal Representative)