



Consent for Verbal Release of Protected Health Information

Use this form to allow Michigan Primary Care Partners to share your Protected health information (also known as PHI) verbally with an individual

Patient Name: _____ Date of Birth _____

Protected Health information to be shared (check one)

☐ Any and all information (this includes appointment dates, scheduling, test results, demographic information, claims, billing, and medical information) **except Super PHI- see additional boxes below.**

☐ Only limited information such as specific treatments, dates of service or billing details
(Please Describe) _____

Check the boxes below if you would also like to include any of the following highly protected information (known as Super PHI):

☐ Substance Abuse Records ☐ Communicable diseases / infection records (STD, TB, HIV, AIDS, Hepatitis)
☐ Mental health treatment records ☐ Family Planning ☐ DNA testing results

I hereby authorize the following people to be verbally made aware of my test results, appointment times, patient account status, and medical information and any other items listed above:

NAME & NUMBER: _____ Relationship: _____

NAME & NUMBER: _____ Relationship: _____

NAME & NUMBER: _____ Relationship: _____

OR

☐ **NO ONE**

I understand that if someone inquires about any of the information listed above and is NOT listed on this consent form, information will NOT be released. I also understand that an additional authorization of release MUST be signed for the nonverbal release of any medical records (printed copies).

Signature: _____ Date: _____

The permission will expire on (check one box only)

☐ On this date (MM/DD/YY) _____ ☐ When canceled in writing, or upon my death



FACT SHEET

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

Complete the **Patient Consent for Verbal Release of Protected Health Information** form to let us know to whom we may speak about your information. List the people you would like us to be able to verbally share information with. Check the appropriate boxes to indicate what information we may discuss.

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

No. If permitted by law, Michigan Primary Care Partners 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 our office address. Forms are available at your clinic, or you can obtain a new form at www.michiganprimarycarepartners.com. [Of note: If an updated **Patient Consent for Verbal Release of Protected Health Information** 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 or check No One?

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 which is available by contacting our office, or by visiting us at our website and selecting patient resources and then patient forms. Our website link is www.michiganprimarycarepartners.com.