Winneshiek MEDICAL CENTER | Physician services by MAYO CLINIC HEALTH SYSTEM

AUTHORIZATION FOR VERBAL COMMUNICATION OF HEALTH INFORMATION

With the implementation of the Health Insurance Portability and Accountability Act (HIPAA), Winneshiek Medical Center 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 your 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 your appointment, test or procedure and you are not available when we call or there is someone who assists with your finances.

The type of information disclosed: Medical history of diagnostic and therapeutic information, unless otherwise specified below.

In addition to the general authorization for verbal communication, I authorize disclosure related to the following when applicable:

Mental Health ❑ Yes ❑ No		Development Disability	❑ Yes ❑ No
AIDS/HIV ❑ Yes ❑ No		Alcohol and/or Drug Abuse	❑ Yes ❑ No

Verbal communication regarding my treatment can be shared with (please print):

Name and Relationship	**Phone Number**	**Type of Information**
		❑ All ❑ Limited to: _____
		❑ All ❑ Limited to: _____
		❑ All ❑ Limited to: _____

How to Contact Me:	**Okay to Call?**		**Okay to leave a Message?**	
Home:	❑ Yes	❑ No	❑ Yes	❑ No
Work:	❑ Yes	❑ No	❑ Yes	❑ No
Cell:	❑ Yes	❑ No	❑ Yes	❑ No
Other:	❑ Yes	❑ No	❑ Yes	❑ No

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. This authorization expires at the end of the current calendar year.

_____ _____
Print Signature Date of Birth

_____ _____
Signature of Patient or Patient's Authorized Representative Date

If signed by authorized representative, please print name, state relationship and the authority to do so.

_____

This form DOES NOT authorize the disclosure of your written health information.