Authorization for Verbal Communication of Protected Health Information

Regarding:

Patient Name:				Date of Birth:	
Address:				Telephone:	
City:		State:		Zip Code:	

I permit Peach Tree Healthcare, their physicians, nurse, and other personnel ("Health Care Providers") to discuss my health information, in person or by telephone, with the following family members or other directly involved in my medical care: (List family members/others and state the person's relationship to the patient).

First and Last Name of Person	Phone Number	Relationship

Release of information under this document is limited to verbal discussions with my Health Care Providers. **This document does not permit release of any written health information to the individuals named above.**

This authorization will expire in one year from signature unless other indicated below:

- ☐ **Indefinite (never expires or until minor child reaches the age of 18)**
- ☐ **Ends on (date)** _____

In accordance with the conditions listed above and on the reverse side of this form, I authorize the use and/or disclosure of my medical information. This authorization includes communication of information regarding psychiatric consults and mental illness, developmental disabilities, alcohol or drug treatment, AIDS or AIDS-related illness, and/or HIV test results (if applicable) unless I limit the discussion to exclude the following medical conditions: _____

_____

Patient Signature: _____ Date: _____

If a representative on behalf of the patient signs this release, complete the following: (please see backside for instruction)

Representative's Name: _____ Relationship to Patient: _____

If, at any time, I do not want verbal discussions to be permitted between my Health Care Providers and any of the individuals named above, I must notify my Health Care Provider by contacting the Medical Records Department at: (530) 749-3242

Additional Information Regarding Communication of Patient Medical Information

Peach Tree Healthcare upholds a patient's right to confidentiality of medical information as provided under federal and state law. Please read the following guidelines before signing this authorization.

Send Authorization to Peach Tree Healthcare: if mailing an authorization, please mail to:

Peach Tree Healthcare
Attn: Medical Records
5730 Packard Avenue Suite 500
Marysville, CA 95901

Verbal Communication Only: This authorization allows for verbal communication between Peach Tree Healthcare and the designated person(s) and/or organization(s) on this form. **It does not allow for copies of medical records to be released.**

No Obligation to Sign: You are not under any obligation to sign this form, and you may refuse to do so. Peach Tree Healthcare may not refuse to provide you treatment or other health care services if you refuse to sign this form.

Revocation: You have the right to revoke this authorization, in writing, at any time before it ends. However, your written revocation will not affect any communication of your medical information that the person(s) and/or organization(s) listed on the reverse side of this form have already made, in reliance on this authorization, before the time you revoke it. Your revocation must be made in writing and addressed to the appropriate originating organization:

Peach Tree Healthcare
5730 Packard Avenue Suite 500
Marysville, CA 95901

Who May Sign This Authorization

1. Generally, all patient 18 years of age or older must sign for communication of their own health information unless the following conditions apply:
    a. The patient is incompetent
    b. The patient is disabled and cannot sign the form
2. All persons signing for communication of health information on behalf of the patient must state their relationship to the patient and provide proof of legal authority of their capacity to act for the patient.
3. Minors: Patient less that 18 years of age must sign for communication of their health information in the following cases:
    a. Alcohol or other drug abuse treatment: age 12 or older
    b. Mental Health Treatment: age 14 and older may consent to communication of their records without parental consent (parent also retain the right to access this information)
    c. HIV test result: age 14 or older
    d. Emancipated minors who are married or in the military.