(Place Patient Identification Label Here)
Do Not Place Label Over Hole Punches

Complete this form in black or dark blue ink only.

Benefis HOSPITALS

CONSENT X UNI-0028

CONSENT FOR VERBAL RELEASE OF HEALTH INFORMATION

PLEASE FILL OUT COMPLETELY

Please complete this form if you wish to grant a representative the ability to communicate with us about you and your health.

Completing this form will enable the person(s) of choice to gain access to talk to us about your care and give and receive information about you.

1. Patient Information

Legal name of Patient _____

Date of Birth _____ Phone number_____

Please provide email address if you would like to access your patient portal_____

2. I authorize Benefis Health System to discuss my medical information with the following individuals:

Individual's Name_____Phone number_____ Relationship_____

Individual's Name_____Phone number_____ Relationship_____

Individual's Name_____Phone number_____ Relationship_____

3. What can be shared verbally with this person(s):

- ☐ To be able to discuss questions about my medication or prescription requests.
- ☐ To be able to ask details of my appointments – e.g., times and dates, to be able to cancel appointments and make appointments when necessary.
- ☐ To be able to discuss any referrals that have been made on my behalf.
- ☐ To be able to discuss my medical care and test results.
- ☐ To be able to discuss my billing and insurance information.
- ☐ All the above
- ☐ Exclude reproductive information.
- ☐ Exclude HIV/AIDS related information and testing.
- ☐ Exclude genetic testing information.
- ☐ Exclude behavioral health information.
- ☐ Exclude substance use information.

4. What are some examples of when this form might be useful?

- 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 an elderly 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.

Patient/Legal Representative Signature	Date	Time	Patient/Legal Representative Printed Name

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5. Revocation of Authorization

I understand that I have the right to revoke this authorization at any time in writing. My revocation does not apply to actions that Benefis Hospitals has already taken in reliance on my valid authorization prior to a revocation; nor does it apply to the disclosure to an insurance company if it is a condition of obtaining insurance coverage.

To revoke this authorization, I must submit the revocation in writing to medical records.

6. Possible redisclosure

I understand that the information that is disclosed in accordance with this authorization is no longer under the control of Benefis Hospitals and may be further disclosed by the receiving party and that it may no longer be protected by federal privacy rules.