WAVERLY HEALTH CENTER

Patient Authorization to Share Health Information

Permission to Verbally Discuss Protected Health Information with Family and Friends
Completion of this form is optional. I understand that my treatment cannot be conditioned on whether or not I sign this authorization.

Patient's Name (Please Print): _____ Date of Birth: _____

I give permission for Waverly Health Center to VERBALLY share the information I have checked with the family, friends or others that I have identified below as being involved in my health care, care coordination or payment of my health care. ***Check all boxes that apply***. **NOTE**: This form does not authorize releasing copies of my records.

- ☐ Scheduling/Appointment information
- ☐ Medical information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Behavioral/Mental health information, including my symptoms, diagnosis, medications and treatment plan
  - ☐ Substance use disorder
  - ☐ Developmental disability
- ☐ Lab/X-ray/Other results ☐ (Check here to include HIV results)
- ☐ Billing and payment information
- ☐ Other (describe): _____

Waverly Health Center has my permission to discuss the above information with the following:

Name: _____ Relationship to Patient: _____

Address: _____

Home phone: _____ Work phone: _____

Name: _____ Relationship to Patient: _____

Address: _____

Home phone: _____Work phone: _____

I understand that in certain situations Waverly Health Center may speak to other individuals who are involved in my care or payment of that care, if permitted by law that may not be identified on this form.

I understand that I have the right to revoke my permission at any time except where Waverly Health Center has already made disclosures in reliance upon this request. I understand this permission remains in effect until the time I revoke it in writing. I will need to complete a new form to reflect changes in this authorization.

_____	_____	_____
Date	Time	Patient Signature/Authorized Representative
_____	_____	_____
Date	Time	If other than patient, state relationship and authority to sign