Hartford HealthCare

Verbal Disclosure Authorization to Friends and Family Involved in Patient's Care

Patient Name: _____ Patient D/O/B: _____

Patient Address: _____ Apt. #: _____

City_____ State: _____ Zip Code: _____

Preferred Phone #: Home: ( ) _____ Cell: ( ) _____

☐ ***I am declining any verbal communications of PHI to anyone other than myself (sign/date below).***

Verbal Communication of Protected Health Information (PHI)

By signing below, I give permission to Hartford HealthCare (HHC) Outpatient office staff to discuss my (or my child's) PHI to designated individuals below from (**check one**):

☐ **All** HHC Outpatient office locations

☐ **Only** from department/specialty listed: _____

Some exclusions to verbal disclosure of PHI with family, friends and others are:

- Verbal discussions with those listed below ***exclude*** information related to HIV, reproductive healthcare services, behavioral health, or substance abuse. A written request to disclose this information is required to be completed by patient.
- This permission does **NOT** allow the below named people to make any medical decisions or to consent to any treatment for me.
- This permission is specific to my/my child's treatment at the above HHC Outpatient Location(s), (but not hospitalization).
- Any requests for **written** Information or **printed** documents contained in my (or my child's) medical record, will require patient to complete and sign a release of information form. (HHC ROI form)

Expiration of this authorization: One Year from date signed

(1) Name: _____ Relationship: _____ Phone: _____

(2) Name: _____ Relationship: _____ Phone: _____

I have carefully read and understand all of the above. I understand that HHC Outpatient staff may continue to share information verbally with the individuals listed above until I revoke this permission by contacting the HHC Outpatient location or complete a new form annually.

Patient/Legal Representative Signature: _____ **Date:** _____ **Time:** _____

Print Name: _____ **Relationship to Patient:** _____

OFFICE USE ONLY:

Revised Date: May 2024 Scan original under "Friends & Family HIPAA" with a description of "Communication of PHI DOS"

Revoke Authorization Workflow Only (Adding Names Requires New Form Completion with Signature):

1. **E-sig:** Advise patient to update on MyChart. If in office, launch new for patient to sign and edit expiration date of existing document.
2. **Paper:** Print current form on same day of request and cross out Named persons and handwrite in top right-hand corner: Today's date, Verbal request by (Patient Name) to delete (Named Person) and Staff initials. Rescan form into record same day. Follow above to scan document BUT in the Description, add the word "Revoke" Communication of PHI". Send original to Document Corrections for removal. ***Staff cannot add names to form. Patient must complete new form.***