HealthPartners®

Permission to Verbally Discuss Protected Health Information with Family and Friends

VERBAL

NAME:

DOB:

MR#: HCL# :

LABEL

—Completion of this form is optional—

Patient name	Date of birth	Medical record number, if known	
Patient street address	City	State	ZIP
Home phone	Work phone		

I give permission for the HealthPartners Family of Care 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)*** **This form does not authorize releasing copies of my records.**

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

The HealthPartners Family of Care has my permission to discuss the above information with the following family member, friend or other person. List only 1 person on each form. This information is directly relevant to their involvement in my health care (or payment for that care).

Name _____

Street address _____

City, State, Zip _____

Home phone _____ Work phone _____

I understand that in certain situations the HealthPartners Family of Care 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 HealthPartners has already made disclosures in reliance upon this request. **I understand this permission remains in effect until the time I revoke it in writing.** If an updated PERMISSION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION WITH FAMILY AND FRIENDS form is received and it has an identical family member/friend/other person listed with updated permissions (different checkboxes), the new version will automatically revoke the previous version on file.

Signature of Patient/Authorized Representative **X** _____ Date _____

If other than patient, state relationship and authority to sign _____

NOTE: For copies of medical records, contact Health Information Management at 952-993-7600 or www.healthpartners.com.

Patient/Staff Instructions: Immediately upon completion send form to HIM (details on back)

Permission to Verbally Discuss Protected Health Information with Family and Friends – Information Sheet

NAME:

DOB:

MR#: HCL# :

LABEL

We have established a process that allows you to tell us who we may talk with about your health care. This includes appointment and scheduling information, lab and test results, treatment information and billing information.

Where do I send the completed form or any changes?

Please send or fax the completed form to HIM (contact list below) or ask hospital or clinic staff to send it for you.

Note: If you need to obtain copies of your health records, contact Health Information Management using the address or phone number of your primary HealthPartners location listed below. For a description of HealthPartners Family of Care, please see Notice of Privacy Practices.

Amery Hospital and Clinic
Release of Information *(office located at Westfields)*
535 Hospital Road, New Richmond, WI 54017
Tel 715-243-3501
Fax 952-883-9731

HealthPartners Medical Clinics
Release of Information
Mailstop: 61N01I
3800 Park Nicollet Blvd., Suite 120
St. Louis Park, MN 55416
Tel 952-993-7600
Fax 952-883-9714

Hudson Hospital and Clinic
Release of Information
405 Stageline Road, Hudson, WI 54016
Tel 715-531-6230
Fax 952-883-9663

Hutchinson Health Hospital & Clinics
Release of Information
1095 Hwy. 15 South, Hutchinson, MN 55350
Tel 320-484-4525
Fax 952-883-3084

Lakeview Hospital/Stillwater Medical Group
Release of Information
927 Churchill Street W.
Stillwater, MN 55082
Tel 651-430-4596
Fax 952-883-9798

Olivia Hospital and Clinic
Release of Information
100 Healthy Way, Olivia, MN 56277
Tel 320-523-8303
Fax 952-883-9670

Park Nicollet/Methodist Hospital/TRIA Orthopaedics
Release of Information
Mailstop: 61N01I
3800 Park Nicollet Blvd., Suite 120
St. Louis Park, MN 55416
Tel 952-993-7600
Fax 952-883-9768

Regions Hospital and Clinics
Release of Information
Mailstop: 61N01I
3800 Park Nicollet Blvd., Suite 120
St. Louis Park, MN 55416
Tel 952-993-7600
Fax 952-883-9614

Westfields Hospital and Clinic
Release of Information
535 Hospital Road, New Richmond, WI 54017
Tel 715-243-3406
Fax 952-883-9729

*** Verbal Disclosure forms for Physicians Neck and Back (PNBC) should be faxed to HealthPartners at 952-883-9714.**

How can I give others permission to get verbal information about me?

Complete the Permission to Verbally Discuss Protected Health Information form on the reverse side of this page to let us know to whom we may speak about your information. List only 1 person on each form. Check the appropriate boxes to indicate what information we may discuss. You may also send us a letter with this information.

Does this mean that you will not speak to anyone I haven't specifically named on the form?

No. If permitted by law, HealthPartners Family of Care may speak to other individuals involved in your care (or payment for that care).

How is the information on the form used?

Anytime your designated person calls or makes a request on your behalf, we will verify the individual has your permission to receive the information and then we will share the information.

What are some examples of when this might be useful?

- If an individual wants to share information with spouse or significant other
- 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 a 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

What if I change my mind?

You can change or revoke (stop) this process at any time by writing to us at the address shown above. Forms are available at your clinic, or you can obtain a new form at www.healthpartners.com. [Of note: If an updated PERMISSION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION WITH FAMILY AND FRIENDS form is received and it has identical family member/friend/other people listed with updated permissions (different checkboxes), the new version will automatically revoke the previous version on file.]

What happens if I don't complete this form?

We will continue to protect your private health information as required by law.

Can the person I designate also get copies of my medical records?

No, they can only receive verbal information. To get copies of medical records, complete a separate Authorization form available by contacting your primary clinic/facility at the phone number listed below, or at www.healthpartners.com.