WILLIAMS INTEGRACARE CLINIC
100 Second Street South, Sartell, MN 56377
(320) 251-2600

Authorization to Verbally Disclose Protected Health Information to Family and Friends

Integracare values your privacy, and we want to protect it as much as possible. By signing this form, you authorize Integracare to disclose information verbally (e.g. via phone, face-to-face) to the individual(s) you list below. This is separate from your emergency contact(s) and separate from an Authorization for Release of Health Information.

Individual(s) Authorized to Receive Information Verbally:

Name (First, Middle, Last)	Birth Date (mm-dd-yyyy)
Relationship to Patient: ☐ Parent ☐ Spouse ☐ Child ☐ Sibling ☐ Other:	
Name (First, Middle, Last)	Birth Date (mm-dd-yyyy)
Relationship to Patient: ☐ Parent ☐ Spouse ☐ Child ☐ Sibling ☐ Other:	
Name (First, Middle, Last)	Birth Date (mm-dd-yyyy)
Relationship to Patient: ☐ Parent ☐ Spouse ☐ Child ☐ Sibling ☐ Other:	
Name (First, Middle, Last)	Birth Date (mm-dd-yyyy)
Relationship to Patient: ☐ Parent ☐ Spouse ☐ Child ☐ Sibling ☐ Other:	
Name (First, Middle, Last)	Birth Date (mm-dd-yyyy)
Relationship to Patient: ☐ Parent ☐ Spouse ☐ Child ☐ Sibling ☐ Other:	

I understand this authorization applies to all Integracare services and locations. The information to be released may consist of my past, present, or future health information including treatment and billing records. **These records may contain information related to behavioral/mental health care, substance abuse treatment, HIV/AIDS, and genetics.** This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing and sent to the Integracare Records Department.
Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by state and federal law. If I want to change/update individuals who can receive verbal information, must submit a New Authorization to Verbally Disclose Protected Health Information form. Integracare will honor the most current version of this form retained in the electronic medical record.

This authorization will not expire unless revoked by you or your legal representative or upon notification of death.

Attention: If this section is incomplete, this form may be invalid. By signing, you agree that you understand and accept the terms on this form.			
Patient/Legal Representative Signature (required)			Date (required) (mm-dd-yyyy)
Printed Name of Person Signing (if not patient) (First, Middle, Last)			
Relationship of Legal Representative to Patient (if applicable)			
Patient Street Address			
City	State	ZIP Code	Phone