

Patient name (Last, First, MI)	Date of birth	Medical record #	
Patient street address	City	State	Zip
Home phone	Work phone		

**At my request, I give Essentia Health permission to *VERBALLY* discuss the following medical and billing information about me (check all boxes that apply):**

- Scheduling/Appointment information
- Medical information, including my symptoms, diagnosis, medications, and treatment plan
- Behavioral health information, including my symptoms, diagnosis, medications, and treatment plan
- Alcohol and/or Drug Abuse information, including my symptoms, diagnosis, medications, and treatment plan
- Lab/test results
- HIV related information (AIDS related testing)
- Billing and payment information including ClearBalance and Western Alliance Bank Account Authorization
- Other (describe): \_\_\_\_\_

Essentia Health has my permission to discuss the above information with:

**1** Name \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Street address \_\_\_\_\_  
 City, State Zip \_\_\_\_\_  
 Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

**2** Name \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Street address \_\_\_\_\_  
 City, State Zip \_\_\_\_\_  
 Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

- I understand the expiration date of this authorization is \_\_\_\_\_ or 1 year from today's date, whichever is sooner.
- I understand that I have the right to revoke my permission at any time except where Essentia Health has already made disclosures in reliance upon this request. I understand I must notify Essentia Health in writing if I want to revoke my permission.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand this consent for release of alcohol and/or drug abuse information is subject to revocation at anytime except to the extent that the program or person, which is to make the disclosure, has already acted in reliance on it.
- I understand that Essentia Health may not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.
- I understand I will receive a copy of this form after I have signed it.
- I understand a photocopy or fax of this form is the same as the original.
- I understand that: (1) my HIV test results may be released without my authorization to persons/organizations that have access under Wisconsin law; and that (2) a list of those persons/organizations is available upon request.

**x** \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Signature (patient/parent of Minor or personal representative) Witness (Signature by mark must be witnessed)



AUT001

Authorization to Verbally Discuss  
Protected Health Information

EH10302 07/22 AUTH.014

Essentia Health knows that privacy regulations have an impact on our customer service to you, especially when it comes to discussing information about you with family, friends, and others you designate who are involved in your care. By completing the Authorization to Verbally Discuss Protected Health Information form, it will allow us to talk about your medical care to those you have designated. This includes appointment and scheduling information, lab and test results, treatment information, and billing information.

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

Complete the Authorization to Verbally Discuss Protected Health Information form to let us know to whom we may speak about your information. Check the appropriate boxes to indicate what information we may discuss.

**How is the information on the form used?**

Any time 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 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.

**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, you must complete a separate Authorization for Use and Disclosure form available at your treating facility.

**What if I change my mind?**

You can change or revoke (stop) this process at any time by notifying us in writing at the address below. This authorization must be renewed annually.

**What happens if I don't complete this form?**

We will continue to protect your private health information as required by law. Completion of this form is optional.

**Where do I send the completed form or any changes?**

Essentia Health – HIM  
407 East Third Street  
Duluth MN 55805  
Fax: 920-593-3114



**Essentia Health**



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