Patient Name:_____

Medical Record Number:_____

Date of Birth: _____

Contact Serial Number:_____

HAR#:_____

GUNDERSEN HEALTH SYSTEM®

La Crosse, WI 54601

# AUTHORIZATION FOR VERBAL COMMUNICATION OF HEALTH INFORMATION

With the implementation of the Health Insurance Portability and Accountability Act (HIPAA), Gundersen Clinic, Ltd. and Gundersen Lutheran Medical Center, Inc. (collectively "Gundersen Health System") must have your specific authorization to share any of your Protected Health Information (PHI) with a spouse or family member or to leave a message regarding your health care on you telephone answering machine. This is especially helpful if you are on medications that require frequent testing and adjustment, in case there is an urgent need to contact you if we need to reschedule an appointment, test or procedure and you are not available when we call or if there is someone who assists with your finances.

**The type of information disclosed:** medical history of diagnostic and therapeutic information, this may include information regarding mental health, developmental disability, HIV, and alcohol and drug abuse, unless otherwise specified below. This form **DOES NOT** authorize the disclosure of any of your written health information.

**Verbal Communication Regarding My Treatment Can Be Shared With** (please print):

| **(Name and Relationship** | **(Phone Number)** | **(Type of Information)** |
|---|---|---|
| _____/_____ | _____ | ☐ All ☐ Only Behavioral Health ☐ Limited to: _____ |
| _____/_____ | _____ | ☐ All ☐ Only Behavioral Health ☐ Limited to: _____ |
| _____/_____ | _____ | ☐ All ☐ Only Behavioral Health ☐ Limited to: _____ |
| _____/_____ | _____ | ☐ All ☐ Only Behavioral Health ☐ Limited to: _____ |

Please indicate below where we may contact you and leave a message regarding your Medical, Behavioral Health and/or Financial information, if appropriate:

Home: _____ Work: _____ Cell: _____

You may refuse to sign this authorization with the understanding that this may result in a delay of treatment and/or potentially adverse health consequences. By signing this form, you understand that at any time, you may change or revoke this authorization. This authorization will expire in two years from the date signed.

_____ _____

Signature of Patient Date

_____

(If signed by authorized person, state relationship and authority to do so.)

**Contact Information Concerning Patient or Legal Guardian:**
(Applicable only if patient is a minor or has a Legal Guardian. PLEASE PRINT)

| _____ | _____ | _____ |
|---|---|---|
| Name | Relationship to Patient | Contact Phone Number |
| _____ | _____ | _____ |
| Name | Relationship to Patient | Contact Phone Number |