LA CLINICA
AFFORDABLE HEALTH CARE EXCELLENCE FOR ALL

PCP:
OR
PCD:

AUTHORIZATION TO VERBALLY DISCLOSE INFORMATION

Patient Full Name _____ **Date of Birth** (MM/DD/YYYY) _____ **Electronic Health Record Number** _____

Many of our patients allow family members such as their spouse, parents, or others to call and request medical, dental, or billing information. Patients may also allow other health care providers to discuss their care. We are not allowed to give this information to anyone without the patient's permission. If you wish to have your medical, dental, or billing information verbally released to a family member or another person, please indicate their name and relationship below:

I authorize La Clinica to verbally disclose the following information to the individual(s) listed below:

(Mark all that apply) ☐**Medical** ☐**Dental** ☐**Billing**

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

I authorize <u>mutual verbal</u> exchange of my health information <u>between</u> the specialist listed above and my La Clinica care team. _____(initial)*

****Sensitive information listed below will <u>not</u> be shared unless initialed****

<u>I UNDERSTAND THAT</u> if the requested information includes any of the sensitive information listed below, additional federal or state laws may apply. By **<u>initialing</u>** next to each section, **I give my permission for the information to be shared.**

Initials: _____ Drug Abuse Diagnosis/Treatment
Initials: _____ Alcoholism Diagnosis/Treatment
Initials: _____ Sexually Transmitted Disease
Initials: _____ HIV/AIDS Test Results
Initials: _____ Genetic Testing Results
Initials: _____ Sickle Cell Anemia
Initials: _____Mental Health Records

<u>I UNDERSTAND THAT</u>:

The information used or shared by this authorization may be re-shared with others. Then it will no longer be protected under federal law. However, I also understand that federal or state law may limit re-disclosure of some of the sensitive information listed above. (45 CFR§164.508 (c)(2)(iii))

I am not required to sign this authorization. Choosing not to sign will not stop me from receiving health care or reimbursement for services. The only time when refusing to sign it may stop me from getting health services is if the services are done only to provide health information to someone else and authorization is needed to send them the information. (45 CFR§164.508 (c)(2)(ii))

I have a right to request, in writing, a list of who has received my health information for reasons other than treatment, payment, health care operations, or disclosures I authorized. I know I can get a copy of this list once every 12 months at no cost.

I may cancel this authorization at any time by sending a written request or by completing the La Clinica Revocation of Authorization form.

If I cancel this authorization, I understand that this does not affect information previously shared. I may not be able to withdraw my authorization if it was done to get insurance coverage. (45 CFR§164.508 (c)(2)(ii))

In La Clinica's school-based health centers, protected information will be used or shared only when needed. The purpose must be related to the child's health, well-being, and ability to learn and succeed.

This authorization shall expire one year after the date signed unless a different expiration date is written here:

Date: _____
(MM/DD/YYYY)

Signature of Patient or Legal Representative/Guardian	Date (MM/DD/YYYY)
Printed Name of Patient/Legal Representative/Guardian	Relationship of Legal Representative or Guardian
Witness Signature *(when signed in office)*	Printed Name of Witness

For Staff Use Only:

□ ROI Documented in Snapshot

Staff Name: _____ Date: _____