



**AUTHORIZATION FOR VERBAL DISCLOSURES**

**Patient Information:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ (Please Print)  
Street Address: \_\_\_\_\_ City/State: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

You have the right to identify individuals other than your health care providers who are involved in your care (family, friends, or others). We may verbally release your medical information to an individual you have identified as involved in your medical care. We may also give information to someone who helps pay for your care. Astria Health will only share your health information with the individuals you designate, except as required or permitted by law. You may add, change or revoke this list at any time. \*\* Please see reverse side for further instructions.

**Information to be disclosed:**

- All aspects of my care, treatment and payment, including insurance, benefits and claims
- All clinical care, including test results and visit documentation
- All billing and insurance information
- Schedule, cancel, reschedule or obtain information about my appointments
- Other (Describe): \_\_\_\_\_

**Special Disclosures: (Please Initial)**

- \_\_\_\_\_ Sexually Transmitted Diseases to include HIV/AIDS
- \_\_\_\_\_ Psychiatric, Mental Health or Behavioral Health Information
- \_\_\_\_\_ Substance Use Disorder (SUD) information

**Restrictions on any of the above marked disclosures:** \_\_\_\_\_

**Individuals to receive verbal communication:**

Name:	Relationship:	Phone Number:
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Permitting to leave detailed phone messages:**

Name:	Relationship:	Phone Number:
_____	_____	_____
_____	_____	_____

**This authorization expires in 365 days from the date of signature or until the date/event specified here:**

**Signature:**

Patient/Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Legal Authority: \_\_\_\_\_

- Self
- Parent
- Legal Guardian
- Medical Power of Attorney

\*\*Please attach Legal Documentation if you are the Legal Guardian or holder of Power of Attorney



## AUTHORIZATION FOR VERBAL DISCLOSURES

### Who may sign this authorization:

- Generally, all patients 18 years of age or older must sign for communication of their own health information unless the patient lacks capacity. Minor consent authority is outlined below.
- All persons signing for communication of health information on behalf of the patient must state their relationship to the patient and provide proof of legal authority of their capacity to act for the patient.
- Release of Information under this document is limited to VERBAL discussions only. This authorization does not authorize release of written information or copies of medical records to the individuals listed. Please use the 'Authorization to Use & Disclose Protected Health Information' Form.

### Consent for Minor:

A signature of a minor patient is required to release information concerning care for:

- Birth control and pregnancy-related care
- Sexually Transmitted Disease information (including HIV/AIDS) if the minor is 14 or older
- Substance Use Disorder diagnosis, treatment, or referral information (for capable minors under 13, both child and guardian must consent)
- Outpatient Mental Health information if the minor is 13 or older

### Prohibition on redisclosure of Health Information:

Federal or State law may restrict the redisclosure or further use of information related to substance use disorders, sexually transmitted diseases, genetic information and information related to mental health.

### Substance Use Disorder program information:

Federal law (42 CFR Part 2) forbids any unauthorized disclosure or additional release of substance use disorder program information without the written consent of the person whose information it is. Capable minors under the age of 13 must consent to disclosures in addition to the parent or legal guardian. Federal rules limit any use of this information to criminally investigate or prosecute any substance use disorder patient. If information is being released to an entity or class of participants under a general designation, upon request, a list of entities the information was disclosed to will be provided according to 42 CFR Part 2.

### Mental Health Services Information:

State law forbids most disclosures of mental health information without specific written consent of the person whose information it is. The parent or legal guardian of a minor child may consent unless the minor patient is 13 or older. In that case, signature of the patient is required. A general authorization to release information is NOT enough for this purpose. (RCW 70.02.230)

### Sexually Transmitted Disease Information (Includes HIV/AIDS):

State law forbids most disclosures of this information without specific written consent of the person whose information it is. The parent or legal guardian of the minor child may consent unless the patient is 14 or older. In that case, the signature of the patient is required. A general authorization to release information is NOT enough for this purpose. (RCW 70.02.220)

### Revocation:

You may revoke this authorization in writing. You may call the Health Information Management (HIM) department for more information and can obtain a copy of the form at: <https://www.astria.health/patients-visitors/medical-records/>. The revocation will be effective upon receipt, but will not apply to information that has already been released or to services already provided according to this authorization. (RCW 70.02.040)

### This Authorization can be sent to us by Mail, Fax or Email:

Astria Health – Attn: Health Information Dept. 1016 Tacoma Ave, Sunnyside, WA 98944

Phone: 509-837-1636, Fax: 509-837-1637, Email: [ROI@Astria.Health](mailto:ROI@Astria.Health)

Monday – Friday, 8:00am – 4:30pm, Closed all major Holidays