Monroe Clinic

AUTHORIZATION FOR VERBAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

This does not authorize release of <u>copies</u> of medical records

Patient Name (or patient label):		Date of Birth:
Address:		Telephone:
City:	State:	Zip Code:

Completion of this document supersedes (replaces/expires) all past documentation for verbal communication on file.

Name	Phone Number	Relationship
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

This authorization has no expiration unless otherwise noted here _____
(mm/dd/yy)

READ CAREFULLY: I authorize the verbal disclosure of my medical information. This authorization includes disclosure of information regarding psychiatric consults and mental illness, developmental disabilities, alcohol or drug treatment, AIDS or AIDS-related illness, and/or HIV test results (if applicable) **unless** I limit the discussion to exclude the following medical conditions:

_____

_____

SIGNATURE OF PATIENT/AUTHORIZED PERSON: _____

****PRINTED NAME OF AUTHORIZED PERSON:** _____

DATE SIGNED: _____
(mm/dd/yy)

**Relationship (if other than self): ☐ Legal Guardian ☐ Power of Attorney ☐ Other _____

If I choose to **withdraw** this authorization or have any questions regarding this form, I will contact the Monroe Clinic Health Information Management Department at (608) 324-2235.

Send signed and dated authorization for verbal communication to Monroe Clinic at:

If **mailing** an authorization, please mail to: M**onroe Clinic,** Health Information Management,
515 22nd Avenue
Monroe, WI 53566

If **faxing** this authorization, please fax to: 608-324-2134
If **emailing** this authorization, please email to: MON-HIM@ssmhealth.com