AUTHORIZATION FOR VERBAL COMMUNCATIONS

This form is used to authorize the release of protected health information in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide *all* information requested may invalidate this authorization.

Name of Patient: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

I, _____, authorize Dominion Center for Behavioral Health Services (DCBHS), their doctors, nurses, clinicians, and other personnel ("health care providers") to discuss health information, in person or by telephone and email, with the following **individuals directly involved in my medical care.**

Name/Organization (please print) **Phone Number/Email** **Relationship**

1) _____

2) _____

Patient's Initials

_____ I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand that by signing this authorization, I am authorizing the release of such information unless specified otherwise above.

RESTRICTIONS:
According to federal and state regulations, if the medical information requested relates to AIDS/HIV treatment or treatment in a federally recognized chemical dependency unit, then the information will be accompanied by a statement limiting disclosure to third parties as required by law.

I understand that if the person or entity that receives the information is not a health care provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I realize that the office and its employees have a responsibility to maintain the confidentiality of the private health information in its possession. I understand that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. The office will not be held responsible for any subsequent disclosure by the recipient of the health information. I release DCBHS, and its employees, of any liability that may arise as a result of any subsequent disclosure of my health information by the recipient.

MY RIGHTS

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.[2]

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:

_____

_____

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

I have a right to receive a copy of this authorization.[3]

Information disclosed pursuant to this authorization could be re-disclosed by the recipient.

Release of Information under this document in limited to **VERBAL** discussions only. This authorization does not authorize release of written information or **copies** of medical records to the individuals listed.

This document has been explained to me and all of my questions have been answered satisfactorily.

SIGNATURE

Signature: _____

Relationship to patient: (Circle one: patient / representative / spouse / financially responsible party)

Date: _____