HealthPartners®

PERMISSION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION WITH FAMILY AND FRIENDS

- Completion of this form is optional -

Patient Name	Date of Birth	Medical record number, if known	
Patient street address	City	State	Zip
Home Phone	Work Phone		

I give permission for the HealthPartners Family of Care to VERBALLY share the information I have checked with the family, friends or others that I have identified below as being involved in my health care, care coordination or payment of my health care. (check all boxes that apply) <u>This form does not authorize releasing copies of my records</u>.

- ☐ Scheduling/Appointment information
- ☐ Medical information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Behavioral health information, including my symptoms, diagnosis, medications and treatment plan
  - ☐ Substance use disorder
  - ☐ Developmental disability
- ☐ Lab/test results (☐ Check here to include HIV results)
- ☐ Billing and payment information
- ☐ Other (describe): _____

The HealthPartners Family of Care has my permission to discuss the above information with the following family, friends and other people. This information is directly relevant to their involvement in my health care (or payment for that care).

1 Name _____
Street Address _____
City, State, Zip _____
Home Phone _____ Work Phone _____

2 Name _____
Street Address _____
City, State, Zip _____
Home Phone _____ Work Phone _____

I understand that in certain situations the HealthPartners Family of Care may speak to other individuals who are involved in my care or payment of that care, if permitted by law, that may not be identified on this form.

I understand that I have the right to revoke my permission at any time except where HealthPartners has already made disclosures in reliance upon this request. **I understand this permission remains in effect until the time I revoke it in writing.**

Signature of Patient/Authorized Representative X _____ **Date** _____

If other than patient, state relationship and authority to sign _____

Patient/Staff Instructions: Immediately upon completion send form to HIM (details on back)

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We have established a process that allows you to tell us who we may talk with about your medical care. This includes appointment and scheduling information, lab and test results, treatment information and billing information.

Where do I send the completed form or any changes?
Please send or fax the completed form to HIM (contact list below) or ask hospital or clinic staff to send it for you:
Note: If you need to obtain copies of your health records, contact Health Information Management using the address or phone number of your primary HealthPartners location listed below.
For a descripton of HealthPartners Family of Care, please see Notice of Privacy Practices:

Regions Hospital and Clinics
Release of Information
Mail Stop 11501E
640 Jackson Street
St. Paul, MN 55101
Tel 651-254-2468
Fax 952-883-9614

Park Nicollet/Methodist Hospital
Release of Information
3800 Park Nicollet Blvd.
St. Louis Park, MN 55416
Tel 952-993-7600
Fax 952-883-9768

Lakeview Hospital
Release of Information
927 Churchill Street W.
Stillwater, MN 55082
Tel 651-430-4596
Fax 651-430-4660

Stillwater Medical Group
Release of Information
1500 Curve Crest Blvd.
Stillwater, MN 55082
Tel 651-439-1234
Fax 952-853-8725

HealthPartners Medical Clinics
Release of Information
Mail Stop 11501K
P.O. Box 1490
Minneapolis, MN 55440-1490
Tel 952-993-7600
Fax 952-883-9714

Amery Hospital and Clinic
Release of Information
265 Griffin Street East
Amery, WI 54001
Tel 715-268-8000
Fax 952-883-9715

Hudson Hospital and Clinic
Release of Information
405 Stageline Road
Hudson, WI 54016
Tel 715-531-6230
Fax 952-883-9663

Westfields Hospital and Clinic
Release of Information
535 Hospital Road
New Richmond, WI 54017
Tel 715-243-2600
Fax 715-243-3414

***Verbal Disclosure forms for Physicians neck and Back (PNBC) and HealthPartners Central Minnesota Clinic (Sartell) should be faxed to HealthPartners at 952-883-9714**

How can I give others permission to get verbal information about me?
Complete the Permission to Verbally Discuss Protected Health Information form on the reverse side of this page to let us know to whom we may speak about your information. Check the appropriate boxes to indicate what information we may discuss. You may also send us a letter with this information.

Does this mean that you will not speak to anyone I haven't specifically named on the form?
No, if permitted by law, HealthPartners Family of Care may speak to other individuals involved in your care (or payment for that care).

How is the information on the form used?
Anytime your designated person calls or makes a request on your behalf, we will verify the individual has your permission to receive the information and then we will share the information.

What are some examples of when this might be useful?
- If an individual wants to share information with spouse or significant other
- If an elderly parent wants an adult child to help understand medical treatment instructions
- If an adult child is helping with billing questions
- If a friend is helping a patient with health issues
- If a college student wants information shared with a parent
- If an adult child calls to find out his/her parent's appointment time

What if I change my mind?
You can change or revoke (stop) this process at any time by writing to us at the address shown above. Forms are available at your clinic, or you can obtain a new form at www.healthpartners.com.

What happens if I don't complete this form?
We will continue to protect your private health information as required by law.

Can the person I designate also get copies of my medical records?
No, they can only receive verbal information. To get copies of medical records, complete a separate Authorization form available by contacting your primary clinic/facility at the phone number listed below, or at www.healthpartners.com.