Authorization For Verbal Disclosure Of Protected Health Information

Johnson Health Center | Administrative Offices
134 Elon Rd Madison Heights, VA 24572
Fax: 434-929-2596

Patient Name: _____ **DOB:**_____ **Last 4 of Soc Sec#:** _____

Street Address: _____**City:** _____**State:** _____**Zip:** _____

I, _____ (Print Name of Person Giving Consent), **hereby authorize Johnson Health Center to verbally disclose and release the following protected health information: (initial all that apply)**

	Medical Office Notes		Statement of Charges and Payments		HIV / Aids / Genetic information
	Lab/X-Ray Results or Images		Alcohol/Substance Information/Drug Screen		Psychological or Mental Health Tests/Reports/Notes
	Dental Records		Other:		Other:

With the following individuals:
(If different health information is authorized to be discussed with different people, a separate authorization needs to be filled out for each person)

_____/_____ _____
(Person) (Relation to Patient) (Phone #)

_____
(Address – Street, City, State, Zip Code)

_____/_____ _____
(Person) (Relation to Patient) (Phone #)

_____
(Address – Street, City, State, Zip Code)

_____/_____ _____
(Person) (Relation to Patient) (Phone #)

_____
(Address – Street, City, State, Zip Code)

_____/_____ _____
(Person) (Relation to Patient) (Phone #)

_____
(Address – Street, City, State, Zip Code)

Unless revoked earlier, this Authorization will expire on the following date, event or condition: _____. **If no expiration date, event, or condition is entered, this authorization will expire 1 year from the date signed.**

_____ _____
(Signature of Person Giving Consent) (Date)

My relationship to the patient is: ☐ **Self** ☐ **Parent** ☐ **Power of Attorney** ☐ **Legal Guardian**
(POA or LG must provide documentation of authorized relationship)

Staff Use: Identification presented: DL _____ State ID _____Other: _____ Staff Name:_____
Medical Records Mailed/Picked up: Date_____ By_____ MR Staff: _____