Permission to Verbally Discuss Protected Health Information with Family and Friends

VERBAL

NAME:

DOB:

—Completion of this form is optional—

Patient name	Date of birth		
Patient street address	City	State	ZIP
Home phone	Work phone		

I give permission for the Blue Spruce Health 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)*** **This form does not authorize releasing copies of my records.**

- ☐ 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): _____

Blue Spruce Health has my permission to discuss the above information with the following family member, friend or other person. List only 1 person on each form. This information is directly relevant to their involvement in my health care (or payment for that care).

Name _____

Street address _____

City, State, Zip _____

Home phone _____ Work phone _____

I understand that in certain situations the Blue Spruce Health 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 Blue Spruce Health has already made disclosures in reliance upon this request. **I understand this permission remains in effect until the time I revoke it in writing.** If an updated PERMISSION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION WITH FAMILY AND FRIENDS form is received and it has an identical family member/friend/other person listed with updated permissions (different checkboxes), the new version will automatically revoke the previous version on file.

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

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

NOTE: For copies of medical records, contact Blue Spruce Health at 802-327-7079 or www.bluespruce.care.