AUTHORIZATION TO VERBALLY RELEASE HEALTH INFORMATION

SOURCE: HIM

Lakewood HEALTH SYSTEM

Name *(first, middle, last)*: ______________________ Birth date: ______________

Lakewood Health System values your privacy and we protect it as much as possible. By signing this form, you authorize Lakewood Health System to release your health information verbally (E.g., via phone or face-to-face) to those you list below. This is separate from your emergency contact(s) and separate from an Authorization to Release Health Information.

Individual(s) authorized to receive health information verbally:

Name *(first, middle, last)*: ______________________ Birth date: ______________
Relationship to patient: ☐ Parent ☐ Spouse ☐ Child ☐ Sibling ☐ Other:

Name *(first, middle, last)*: ______________________ Birth date: ______________
Relationship to patient: ☐ Parent ☐ Spouse ☐ Child ☐ Sibling ☐ Other:

Name *(first, middle, last)*: ______________________ Birth date: ______________
Relationship to patient: ☐ Parent ☐ Spouse ☐ Child ☐ Sibling ☐ Other:

Name *(first, middle, last)*: ______________________ Birth date: ______________
Relationship to patient: ☐ Parent ☐ Spouse ☐ Child ☐ Sibling ☐ Other:

Name *(first, middle, last)*: ______________________ Birth date: ______________
Relationship to patient: ☐ Parent ☐ Spouse ☐ Child ☐ Sibling ☐ Other:

I understand this authorization applies to all Lakewood Health System services and locations. The information to be released may consist of my past, present, or future health information including treatment and billing records. These records may contain information related to behavioral/mental health care, substance abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing and sent to Health Information Management.

Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the state and federal law. If I want to change/update individuals who can receive verbal information, I must submit a new Authorization to Verbally Release Health Information form. Lakewood Health System will honor the most current version of this form retained in the electronic health record.

This authorization will not expire unless revoked by you or your legal representative, or upon notification of death.

Attention: If this section is incomplete, this form may be invalid. By signing, you agree you understand and accept the terms in this form.

Patient/legal representative signature *(required)*: ______________________ Date: ______________

Full name of person signing *(if not patient)*: ______________________

Relationship of legal representative to patient *(if applicable)*: ______________________

Address: ______________________

City: ____________ State: ____________ Zip: ____________ Phone: ____________

Return form to:
Release of Information – Lakewood Health System
49725 County 83
Staples, MN 56479
Phone: 218-894-8641
Fax: 218-894-8767
Email: medicalrecords@lakewoodhealthsystem.com

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