Obtaining Verbal/Written Authorization (Permission) to Use or Disclose Protected Health Information

From time to time Mason Health may wish to use or disclose your protected health information to individuals involved in your care for notification purposes. As stipulated by Title 45, Section 164.10, we are permitted to make such uses or disclosures after we have obtained your verbal or written permission.

Mason Health is authorized to: (please check all that apply)

- ☐ Notify or speak with my spouse regarding treatment or proposed treatment.

  (please specify name): _____

- ☐ Notify or speak to my caregiver regarding treatment or proposed treatment.

  (please specify name): _____

- ☐ Notify or speak to my family members, i.e., children, sister, brother, mother, father, of treatment or proposed treatment. (please

  specify name(s)): _____

- ☐ Notify or speak to my friend regarding treatment or proposed treatment.

  (please specify name(s)): _____

- ☐ Notify my transportation service regarding my delivery or pick-up prior to or upon completion of my treatment.
- ☐ Include information about my mental health. ***IF PATIENT HAS REACHED HIS/HER THIRTEENTH (13) BIRTHDAY, ONLY THE PATIENT CAN AUTHORIZE DISCLOSURE RELATING TO THE ABOVE SPECIFIED CONDITIONS.
- ☐ Other: (please specify): _____

How may we contact you with reference to your appointment, proposed treatment, follow-up appointments, billing questions/ problems, surgery scheduling, radiology/lab/outpatient service appointments and other situations regarding your protected health information?

If I am not available, Mason Health may: (please check all that apply)

- ☐ Leave a message with my spouse or those members listed above.
- ☐ Leave a message on my answering machine, voice mail or cell phone.
- ☐ Call my place of employment and leave a message for me to return the call.
- ☐ Leave a message with my referring doctor's office to have me return the call.
- ☐ Leave a message with my interpreter.
- ☐ Other:_____

I understand that I may refuse to sign this authorization. I understand my refusal will not affect my ability to obtain treatment at any Mason Health campus.

I may revoke this authorization at any time by submitting a written notice of revocation to Mason Health. The revocation will be effective at Mason Health upon receipt of my written notice, except that it will not have any effect on any action already taken by Mason Health on this authorization.

I understand that once Mason Health has disclosed my health information to the recipient, Mason Health cannot guarantee that the recipient will not re-disclose my health information to a third party.

This authorization will remain valid as long as I am a patient at Mason Health. By my signature below, I hereby, knowingly and voluntarily, authorize Mason Health to verbally disclose my health information or fulfill specific instructions in the manner described above and revoke all previously signed Clinic Verbal Authorization forms.

Patient/Representative Signature: _____ Date/Time: _____

Printed Name of Personal Representative: _____ Relationship: _____

Patient Label