

9200 SE 91st Avenue, Suite 200, Portland, OR 97086
Telephone: 503.233.5548 Facsimile: 503.230.1009
www.MtScottENT.com

Release of Verbal Medical Information

Patient Name: _____ DOB: _____

Mt Scott ENT restricts the release of protected health information (PHI) to that permitted by patient confidentiality laws. According to HIPAA regulations, permitted reasons for release of PHI include treatment, payment and healthcare operations, or as otherwise allowed by the specific signed authorization of the patient or authorized personal representative.

The purpose of this Release of Verbal Medical Information form is to provide our patients an opportunity to permit verbal release of PHI in the following two (2) ways:

Certain information cannot be released without specific authorization as required by state or federal law. By initialing the lines below, you authorize the release of the following protected or sensitive information:

- Diagnosis and Treatment Plans
Labs and Imaging results and scheduling
Prescription information
Billing and Insurance Claims

Release of Verbal Medical Information

This authorization will expire 730 days (2 years) from the date of signing.

I understand that I have the right to revoke this authorization, in writing, at any time.

I understand that such revocation is not effective to the extent that the clinic has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by state or federal law.

This form is not valid unless signed and dated.

I. Permission to Verbally Discuss PHI with Family Members/Caregivers

I hereby authorize medical providers and personnel of Mt Scott ENT to discuss my protected health information with the following person(s):

Name/Phone number: _____ Relationship: _____

Name/Phone number: _____ Relationship: _____

Name/Phone number: _____ Relationship: _____

-or- I decline. Please do not discuss my care with anyone other than as allowed by HIPAA regulations.

II. Permission to Leave a Detailed Message: I hereby authorize medical providers and personnel of Mt Scott ENT to leave a detailed message at the following phone number:

_____ and/or e-mail address: _____

-or- I decline. Please do not leave me detailed messages.

Signature of Patient/Personal Representative Name of Patient/Personal Representative

Date Description of Personal Representative's Authority

MT  SCOTT

EAR, NOSE AND THROAT, & SLEEP MEDICINE

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