Lindner Center of HOPE

Professional Associates

AUTHORIZATION FOR VERBAL COMMUNICATION TO SHARE PATIENT PROTECTED HEALTH INFORMATION

PATIENT INFORMATION (Please Print)

Last, First, MI	Date of Birth	Medical Record #

PROTECTED HEALTH INFORMATION (PHI) TO BE VERBALLY OBTAINED OR DISCLOSED

INPATIENT Dates of Service: _____ **and/or Outpatient Dates of Service:** _____

To better treat you as a patient of Lindner Center of HOPE, it may be necessary to communicate and collaborate with other health care providers or family members.

I authorize Lindner Center of HOPE staff to verbally share my protected health information with those individuals listed.

Individual/Agency/Hospital: _____

Address: _____ Phone #: _____

Email address (for non urgent communication; sent encrypted: _____

Restrictions - Please include any information you do not want shared: _____

Individual/Agency/Hospital: _____

Address: _____ Phone #: _____

Email address (for non urgent communication; sent encrypted: _____

Restrictions - Please include any information you do not want shared: _____

Individual/Agency/Hospital: _____

Address: _____ Phone #: _____

Email address (for non urgent communication; sent encrypted: _____

Restrictions - Please include any information you do not want shared: _____

I, the undersigned, authorize Lindner Center of HOPE, 4075 Old Western Row Road, Mason, OH 45040 to use and/or disclose information from my medical or financial record as specified above.

I understand and acknowledge that this authorization extends to all or any part of the records designated above, which may include documentation of treatment for mental health disorders, alcohol/drug abuse or dependence, and/or HIV/AIDs test results or diagnosis. I expressly consent to the release of information as designated above. Furthermore, I consent to the release of the facsimile transmission of my protected health information as necessary.

This authorization will expire in twelve (12) months unless otherwise specified. I understand that I or my legal representative may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance of this authorization.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits, unless the treatment is for research purposes or unless the provision of treatment is related solely to the disclosure of my PHI to a third party such as when requested by my employer.

I understand that if the person/entity that receives the above PHI is not a health care provider/health plan covered by federal privacy regulations, the PHI described above may be re-disclosed by such person/entity and will likely no longer be protected by the federal privacy regulations.

Patient Signature (if 18 years of age or older)	Date/Time
Signature of ☐ Parent ☐ Legal Guardian (check one)	Date/Time
Witness	Date/Time

This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as other wise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.