AUSTIN HAND GROUP

Permission to Verbally Discuss Protected Health Information

To our Patients:
Privacy policies set limits on what we are allowed to discuss about you and your medical conditions with family, friends, and other people who are involved in your care. This form allows you to tell us who we may talk with about your medical care. This includes appointment and scheduling information, lab and test results, treatment information and billing information. This does not allow listed individuals access to copies of your medical records. To obtain copies of medical records your must complete a separate "Authorization to Disclose Medical Records" release form. You can change or stop this authorization at any time in writing.

Examples when this might be useful:

- If a patient wants information shared with a spouse or another person
- If an elderly parents wants an adult child to help with medical treatment instructions, billing questions, or scheduling appointments.
- If a friend is helping with treatment instructions or health issues
- If a college student/young adult wants information shared with a parent

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Phone#: _____

I give permission to Austin Hand Group to **VERBALLY** discuss information about me with:

Name: _____ Relationship: _____

Phone#: _____

Check all boxes that apply:

☐ Scheduling/Appointment Information
☐ Medical information (symptoms, diagnosis, medications, and treatment plan)
☐ Billing and payment information

I give permission to Austin Hand Group to **VERBALLY** discuss information about me with:

Name: _____ Relationship: _____

Phone#: _____

Check all boxes that apply:

☐ Scheduling/Appointment Information
☐ Medical information (symptoms, diagnosis, medications, and treatment plan)
☐ Billing and payment information

I have the right to change or revoke my permission in writing at any time except where Austin Hand Group has already made disclosures in trust of this original request. **I understand that I must complete a new form or notify Austin Hand Group in writing if I want to change or revoke any of the permissions indicated above.**

_____ _____

Signature of Patient or Authorized Representative Date