Permission to Verbally Discuss Protected Health Information

**Note: Completion of this form is optional. To be valid, this form must be filled out COMPLETELY, including what information you are giving us permission to share.*

Patient Name: _____ Date of Birth: _____
(Please Print)

Preferred Phone number_____ Work Phone Number (Optional) _____

☐ **I give permission to Associated Eye Care to leave a voicemail message for me at the *Preferred Phone Number* listed above *or at the Work Phone Number, if provided.***

I give permission to Associated Eye Care to VERBALLY discuss the medical and billing information indicated below with the following individuals:

Name	Phone	Relationship to Patient

(Check all Boxes that apply):

☐ Scheduling/ Rescheduling/ Cancelling and any other appointment information
☐ Medical information, including my symptoms, diagnosis, medications, and treatment plan...
☐ Lab/test results
☐ Billing and payment information
☐ Other: _____

I understand that I may cancel this permission at any time (by writing to Associated Eye Care Health Information), but that cancelling it will not affect any information that has already been released.

This authorization expires ☐ When I cancel it in writing or on this date → ☐ _____ (*specify date*)

If no expiration date is specified, this authorization will remain in effect until Associated Eye Care Health Information receives written notice to cancel it.

_____ _____
Signature of patient/guardian *Circle one* Date

_____ _____ _____
Witness if patient is unable to sign Date Reason patient is unable to sign

If authorized representative, please sign and attach copies of supporting legal documentation.

Associated Eye Care knows that privacy regulations have an impact on our customer service, especially when it comes to discussing information about you with family, friends, and others you designate who are involved in your care. We have established a process that allows you to tell us who we may talk with about your medical care. This includes appointment scheduling information, lab and test results, treatment information and billing information.

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Informational Sheet only- No signature required on this page

How can I give others permission to get verbal information about me?

Complete the Permission to Verbally Discuss Protected Health Information form on the reverse side of this page to let us know to whom we may speak about your information. Check the appropriate boxes to indicate what information we may discuss. You may also send us a letter with this information.

How is the information on the form used?

Anytime your designated person calls or makes a request on your behalf, we will verify the individual has your permission to receive the information before we will share the information.

What are some examples of when this might be useful?

- If an elderly parent wants an adult child to help understand medical treatment instructions
- If an adult child is helping with billing questions
- If a friend is helping an elderly patient with health issues
- If a college student wants information shared with a parent
- If an adult child calls to find out his/her parents appointment time

Can the person I designate also get copies of my medical records?

No, they can only receive verbal information. To get copies of medical records, you must complete a separate Authorization form available at our clinics, by calling 651-275-3026, or at www.associatedeyecare.com

What if I change my mind?

You can change or revoke (stop) this process at any time by writing to us at the address shown below. Forms are available at your clinic, or you can obtain a new form at www.associatedeyecare.com.

What happens if I don't complete this form?

We will continue to protect your private health information as required by law.

Where do I send the completed form or any changes?

Mail to:
Associated Eye Care
ATTN: Health Information
1719 Tower Drive. Suite 100
Stillwater, MN 55082

Questions Call:
651-275-3026

Or Fax to:
651-275-3032

Or Email to:
Him@associatedeyecare.com