WinnMed

AUTHORIZATION FOR VERBAL COMMUNICATION OF HEALTH INFORMATION

With the implementation of the Health Insurance Portability and Accountability Act (HIPAA), WinnMed must have your specific authorization to share any of your Protected Health Information (PHI) with a spouse or family member.

The type of information disclosed: Medical history of diagnostic and therapeutic information, unless otherwise specified below.

In addition to the general authorization for verbal communication, I authorize disclosure related to the following when applicable:

Mental Health	❑ Yes ❑ No	Development Disability	❑ Yes ❑ No
AIDS/HIV	❑ Yes ❑ No	Alcohol and/or Drug Abuse	❑ Yes ❑ No

Verbal communication regarding my treatment can be shared with (please print):

Name and Relationship	Phone Number	Type of Information
		❑ All ❑ Limited to: _____
		❑ All ❑ Limited to: _____
		❑ All ❑ Limited to: _____

By signing this form, you understand that at any time, you may change or revoke this authorization. This authorization expires one year after the signed date

_____ _____
Print Name Date of Birth

_____ _____
Signature of Patient or Patient's Authorized Representative Date

If signed by authorized representative, please print name, state relationship and the authority to do so.

_____

This form DOES NOT authorize the disclosure of your written health information.