St. Elizabeth Medical Center

AUTHORIZATION FOR VERBAL DISCLOSURE OF PROTECTED HEALTH INFORMATION

Authorization must be signed by the patient if age 18 or over by a minor patient (under 18) if emancipated or otherwise eligible pursuant to KRS 214.185; or by the parent or legal guardian for any other minor; or by the patient's legally authorized representative if the patient is otherwise unable to consent (See HIPAA Policy 100.133.00)

I, _____, hereby authorize St Elizabeth Medical Center to verbally disclose the following specific health information:

_____
_____
_____

For the purpose of:

_____**Involvement in Care**_____

To the person(s) or entity(ies) listed here: _____
_____

Verification of the individual's identity will be required prior to disclosure.

Effective Date: _____.

I have the right to revoke this authorization in writing at any time. A written revocation should be sent to:

PHI Coordinator
1 Medical Village Dr.
Edgewood, Ky. 41017

This authorization will expire on (date) _____.
(If blank this form will automatically expire at the end of stay)

I realize that St Elizabeth Medical Center will not condition my treatment, payment functions, or other health care operations based on whether or not I agree to this authorization, and that my participation is voluntary.

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

St Elizabeth Medical Center will provide me with a copy of this signed authorization.

_____
Patient's or Personal Representative's Signature

_____
Authority for Personal Representative

_____
Dated

_____
Witness