(For Official Use Only)

PATIENT NAME _____

DATE OF BIRTH _____

MEDICAL RECORD #_____

RUSH

VERBAL RELEASE OF PATIENT HEALTH INFORMATION AUTHORIZATION

Verbal Release of PHI Authorization

IDN1510363

INSTRUCTIONS: Complete this form to permit Rush University Medical Center and/or Rush Oak Park Hospital (Rush) to VERBALLY discuss the information selected below with the individuals whom you designate on this form.

PATIENT INFORMATION:

Name _____ Maiden Name_____ Birth date ___ /___ /___ Phone # _____

Address _____ City_____ State _____ Zip _____

INFORMATION TO BE VERBALLY RELEASED: By signing below, I give permission to Rush to discuss the following medical and billing information about the above-named patient (check all boxes that apply):

☐ Scheduling/appointment information
☐ Medical information, including my symptoms, diagnosis, medications, and treatment plan.
☐ Sensitive information about sexually transmitted disease (STD) testing, HIV/AIDS testing and treatment, pregnancy testing, prenatal care, birth control and family planning
☐ Behavioral health information, including my symptoms, diagnosis, medications and treatment plan
☐ Chemical dependency information, including my symptoms, diagnosis, medications, and treatment plan
☐ Lab/test results
☐ Billing and payment information
☐ Other _____

Rush has my permission to discuss the above-selected information with the individual(s) identified below for the purpose of allowing such individual(s) to be involved in my care and/or for communicating the status of my condition and treatment. I understand that this authorization applies to both information that is contained in my Rush health record on the date of my signature below, as well as all information that is entered into my health record during the period of time that this authorization is in effect. I further understand that in order to prevent information entered into my health record during the effective period of this authorization from being shared with the individuals identified above, I must revoke this authorization as described on page 2.

(1) Name: _____ Relationship: _____ Home Phone:_____

(2) Name: _____ Relationship: _____ Home Phone:_____

(3) Name: _____ Relationship: _____ Home Phone:_____

(4) Name: _____ Relationship: _____ Home Phone:_____

I understand that I do not have to sign this form, and that I should only sign it to permit Rush to share the information identified above with someone involved in my care. By signing below, I acknowledge and agree that I received page 2 of this form, which describes my rights related to this authorization.

PATIENT/PERSONAL REPRESENTATIVE'S SIGNATURE:

_____ Date: _____
Signature of Patient or Personal Representative

_____ Phone #_____
If signed by other than patient: PRINT representative name

_____
If signed by other than patient: State relationship to patient

*(Signature of a witness who has verified the patient/personal representative's identity is required for mental health/developmental disability, genetic testing, HIV, and drug/alcohol records. Additionally, signature of patient is required for mental health records if over the age of 12 and under the age of 18.)

_____ Date: _____
Witness signature

_____ Phone #_____
PRINT Witness name

_____
State relationship to patient

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PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

This authorization is voluntary. Rush will not condition your treatment on giving this authorization. However, Rush may condition the provision of research-related treatment on the provision of an authorization.

I understand that I may change my mind and revoke this authorization at any time by giving written notice of my revocation to the contact office listed above. I understand that revocation of this authorization will not affect action Rush took in reliance on this authorization before Rush received my written notice of revocation.

I authorize the use and/or disclosure of my Protected Health Information (PHI) as described above. I understand that this authorization is voluntary and made to confirm my decision so Rush may use and/or disclose my PHI for a specific purpose. I understand that if the persons or organizations I authorized above to receive and/or use the PHI described above are not subject to federal health information privacy laws, they may further disclose the PHI and it may no longer be protected by federal health information privacy laws. I understand that I have a right to inspect and copy the information to be disclosed pursuant to this authorization and that I may obtain a copy of the information by contacting the office listed above.

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to Rush. I understand that, by signing this form, I am confirming my authorization that Rush may use and/or disclose to the persons and/or organizations named in this form the PHI described in this form.

EFFECTIVE: If you are authorizing us to disclose information regarding your behavioral health treatment, this authorization is valid for fifty years from the date of signature unless you provide another date upon which your authorization will expire. For release of all other information, this authorization will be valid for as long as you are a patient of Rush unless you choose to provide a date or event (related to you or the purpose of the use/disclosure) upon which your authorization will expire.

FREQUENTLY ASKED QUESTIONS

Rush knows that privacy regulations have an impact on our customer service to you, especially when it comes to discussing information about you with family, friends, and others involved in your care. Therefore, we have established a process that allows you to tell us with whom we may discuss your medical care. This may include appointment scheduling information, lab and test results, treatment information and billing information.

How can I give others permission to get verbal information about me?
Complete the attached Verbal Release of Protected Health Information form to let us know to whom we may speak about your information. Check the appropriate boxes to indicate what information we may discuss.

How is the information on the form used?
Anytime your designated person(s) call or make a request on your behalf, we will verify the individual has your permission to receive the information and then we will share the information that you selected on the Verbal Release of Protected Health Information form.

What are examples of when the ability of a friend or family member to learn medical information about me might be useful?
- If an elderly parent wants an adult child to help understand medical treatment instructions or billing
- If a friend is helping a patient with health issues
- If a college student wants information shared with a parent
- If an adult child calls to find out his/her parent's appointment time

Can the person I designate also get copies of my medical records?
No. An individual designated to receive information on the Verbal Release of Protected Health Information form can only receive verbal information. To get copies of medical records, you must complete a separate form (Authorization for Release of Patient Health Information) available at Rush, by calling 312-942-7262, or online at www.rush.edu.

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 or by completing a new form. Forms are available at Rush, or you can obtain a new form online at www.rush.edu.

What if I don't complete this form?
We will continue to protect your private health information in the manner required by law.

Where do I send the completed form or any changes?
The completed form can be returned to your doctor's office, or mailed to the Rush Health Information Management Office at the following address:
Rush University Medical Center
ATTN: Health Information Management Office
1611 West Harrison Street, L1, Suite 001, Chicago, IL 60612
Fax: (312) 942-5549