Crossing Rivers Health Clinic
37822 US Hwy 18 Prairie du Chien, WI 53821
Phone: 608-326-1072

AUTHORIZATION FOR VERBAL COMMUNICATION OF HEALTH INFORMATION

Patient Name: _____ Race: _____

DOB: _____ Ethnicity: _____

With the implementation of the Health insurance Portability and Accountability Act (HIPAA), Crossing Rivers Health Clinic must have your specific authorization to share any of your Protected Health Information (PHI) with a spouse or family member or anyone you choose or to leave a message regarding your health care on your telephone answering machine. This is especially helpful if you are on medications that require frequent testing and adjustment, in case there is an urgent need to contact you, if we need to reschedule an appointment, test or procedure and you are not available when we call or if there is someone who assists with your finances.

The type of information disclosed: medical history of diagnostic and therapeutic information, this may include information regarding her mental health, developmental disability, HIV, and alcohol and drug abuse, unless otherwise specific below.

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:_____

EMPLOYER/ADDRESS/PHONE: _____

EMAIL ADDRESS: _____

EMERGENCY CONTACT: _____ PHONE: _____

RELATIONSHIP: _____

How to Contact Me	Okay to Call?		Okay to Leave a Message?	
Home: _____	Yes	No	Yes	No
Work: _____	Yes	No	Yes	No
Cell: _____	Yes	No	Yes	No
Other: _____	Yes	No	Yes	No
Mail: Send letter to home address:	Yes	No	Yes	No

Send letter to alternative address: _____

You may refuse to sign this authorization with the understanding that this may result in a delay of treatment and/or potentially adverse health consequences. By signing this form, you understand that at any time, you may change or revoke this authorization. This authorization will expire when you notify us of expiration.

Printed Name

_____ _____

Signature of Patient **Date**

_____ _____

(If signed by authorized person, state relationship and authority to do so.) Date