Voyage HEALTHCARE
~ Health Begins Here ~

Permission to Verbally Discuss Protected Health Information

~Completion of this form is optional ~

Patient Name			Date of Birth
Patient Street Address	City	State	Zip
Preferred Phone Number	Work Phone Number (optional)		

☐ **I give permission to Voyage Healthcare to leave a voicemail message for me at the *Preferred Phone Number* listed above.**

☐ **I give permission to Voyage Healthcare to send me SMS/text messages for appointments and other healthcare related messages.**

☐ **I give permission to Voyage Healthcare to VERBALLY discuss information about me with:**

Name: _____Relationship: _____
Home/Cell phone: _____ Work phone: _____

Check all boxes that apply:

- ☐ Scheduling / Appointment information
- ☐ Medical information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Behavioral health information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Chemical dependency information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Billing and payment information
- ☐ Other (describe): _____

☐ **I give permission to Voyage Healthcare to VERBALLY discuss information about me with:**

Name: _____Relationship: _____
Home/Cell phone: _____ Work phone: _____

Check all boxes that apply:

- ☐ Scheduling / Appointment information
- ☐ Medical information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Behavioral health information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Chemical dependency information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Billing and payment information
- ☐ Other (describe): _____

I have the right to change or revoke my permission in writing at any time except where **Voyage Healthcare** has already made disclosures in trust of this original request. **I understand that I must complete a new form or notify Voyage Healthcare <u>in writing</u> if I want to change or revoke any of the permissions indicated above.**

Signature of Patient/Authorized Representative X_____
(If authorized representative, please sign and attach copies of supporting legal documentation)

Date: _____

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Protected Health Information

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To our Patients:
Privacy rules set limits on what we are allowed to discuss about you with family, friends and other people who are involved in your care. This form allows you to tell us who we may talk with about your medical care. This includes appointment and 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 Permission to Verbally Discuss Protected Health Information form on the other side of this page and list people we may speak to about your information. Check the boxes next to the information we may discuss. You may also send us a letter with this information.

How is the information on the form used?
When a person you listed calls or makes a request on your behalf, we will verify the person is listed to receive the information and then we will share the information.

What are some examples of when this might be useful?

- If a patient wants information shared with a spouse or another person
- If an elderly parent wants an adult child to help:
  - understand medical treatment instructions
  - answer billing questions
  - schedule and confirm appointments
- If a friend is helping an elderly patient with health issues
- If a college student wants information shared with a parent

Can the person I list 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 to Release and Disclose Patient Information form available at any Voyage Healthcare office, by calling 763-587-7999 or at www.voyagehealthcare.com

What if I change my mind?
You can change or stop this process at any time by writing to us at the address shown below. New copies of this form are available at any Voyage Healthcare office or you can print a new form from our website at www.voyagehealthcare.com

What happens if I don't complete this form?
We will continue to protect your private health information as we always have and as required by law.

Where do I send the completed form or any changes?

Mail to: OR Fax to: 763-587-7989

Voyage Healthcare Medical Records Department
5109 – 36th Ave N.
Crystal, MN 55422

For other medical records questions, please call: 763-587-7999 option 3.

NOTE: To obtain copies of medical records, you will need to complete a Voyage Healthcare Authorization to Release and Disclose Patient Information form.