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

I, _____, hereby authorize St. Elizabeth Healthcare to verbally disclose
(patient name)
the following specific health information:

_____

_____

For the purpose of: **Involvement in Care**

To the person(s) listed here: _____

_____

Verification comments: _____
(Verification of the individual's identity will be required prior to disclosure)

I realize this authorization will automatically expire when patient is discharged from current service.

I realize that St. Elizabeth Healthcare 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.

_____
Patient or Personal Representative Signature

_____
Authority for Personal Representative

_____
Effective Date

_____
Witness

I realize I have the right to revoke this authorization at any time by completing the following.

_____
Revoked By

_____
Effective Date

_____
Witness

St. Elizabeth Healthcare will provide the patient with a copy of this signed authorization.