Cascade Infectious Diseases
A Practice of Oregon Specialty Group

Authorization for Verbal Communication of Protected Health Information to Family or Friends

This form documents my request to allow family members and/or friends to be involved in verbal discussions regarding my health care. This authorization must be written, dated and signed by the patient or their legal representative.

Patient's Name: *(please print)*: _____ Date of Birth: _____

Other Names/Nicknames: _____ Phone #: _____

Street Address: _____ City, State & Zip: _____

Email Address: _____

Authorization for release of verbal information can be revoked at any time by the patient in writing, but it is NOT retroactive to the release of information made in good faith.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

_____ _____
Signature of Patient or Legal Representative Date

I authorize Cascade Infectious Diseases to discuss protective health information about me to the following individuals:

Name	Relationship	Phone #	May be listed as an Emergency Contact
_____	_____	_____	YES | NO
_____	_____	_____	YES | NO
_____	_____	_____	YES | NO

1. Type of information to be shared or disclosed *(excludes copies of medical records):*

   ☐ Appointment Information ☐ Prescription Information ☐ All Information

2. I authorize Cascade Infectious Diseases to leave detailed phone messages about my medical and health plan information via:

   ☐ Voicemail on my phone number(s) ☐ With person answering my phone number(s)
   ☐ Email ☐ USPS Mail ☐ All Options

3. Mark this box if you *do not authorize* Cascade Infectious Diseases to discuss protective health information about me with others. ☐