HEALTHREACH
COMMUNITY HEALTH CENTERS

2025 PERMISSION TO VERBALLY SHARE PROTECTED HEALTH INFORMATION WITH PEOPLE INVOLVED IN YOUR CARE

Name:_____ Date of birth: _____

Name used when treatment occurred (if different from above): _____

Use this form to give permission to HRCHC employees to verbally share your protected health information with a friend, family member, or person assisting in your care or payment for your care.

I give permission to HRCHC to speak to the person/people listed below regarding my protected health information relevant to their involvement in my care or my payment for care:

If there is something specific that you do not want disclosed, please write here: _____

Name of person:_____ Phone number(s):_____ Relationship:_____.

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If I have been diagnosed or treated for any of the following, I understand that the disclosing entity needs my specific consent. Indicate whether you DO or DO NOT authorize the verbal release of protected health information for each of the following by initialing the appropriate box.

I DO	**I DO NOT**	Authorize the release of verbal PHI regarding treatment for **SUBSTANCE USE DISORDER PROGRAM RECORDS AND INFORMATION PROTECTED BY 42 C.F.R PART 2.**
initials	**initials**	
I DO	**I DO NOT**	Authorize the release of verbal PHI regarding treatment **outside** of HRCHC for **MENTAL HEALTH AND BEHAVIORAL HEALTH**. I understand that I have the right to review any medical records containing PHI related to my mental and behavioral health that is maintained by licensed mental health facilities or agencies at any reasonable time before deciding to authorize the disclosure on this form.
initials	**initials**	
I DO	**I DO NOT**	Authorize the verbal disclosure of **HIV/AIDS INFORMATION, INCLUDING** test results. I understand that there are potential risks associated with the disclosure of HIV/AIDS information including but not limited to discrimination and changes in family and social relationships.
initials	**initials**	

I, the undersigned, hereby authorize HealthReach Community Health Centers and its designated employees or agents to discuss my protected health information with the individuals indicated above consistent with this form. This permission will be in effect until I revoke it. I may revoke this permission any time by contacting HealthReach Community Health Centers.

Signature of Patient/Authorized Representative:_____ Date: _____

If signed by an Authorized Representative:

Printed Name:_____ Legal Authority*: _____

**Describe your legal authority to act on behalf of the patient (e.g., guardian, power of attorney agent). We may require documentation of your authority.*

If this authorization authorizes disclosure of substance use disorder program information protected by 42 C.F.R. Part 2:

Notice to Recipient of Prohibition on Redisclosure: This record which has been disclosed to you is protected by Federal confidentiality rules (42 CFR part 2). These rules prohibit you from using or disclosing this record, or testimony that describes the information contained in this record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against the patient, unless authorized by the consent of the patient, except as provided at 42 CFR 2.12(c)(5) or as authorized by a court in accordance with 42 CFR 2.64 or 2.65. In addition, the Federal rules prohibit you from making any other use or disclosure of this record unless at least one of the following applies: (i) further use or disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or as otherwise permitted by 42 CFR part 2; (ii) you are a covered entity or business associate and have received the record for treatment, payment, or health care operations; or (iii) you have received the record from a covered entity or business associate as permitted by 45 CFR part 164, subparts A and E. A general authorization for the release of medical or other information is NOT sufficient to meet the required elements of written consent to further use or redisclose the record (see 42 CFR 2.31).