Winona Health

AUTHORIZATION FOR VERBAL EXCHANGE OF MEDICAL INFORMATION

Patient Name: _____

Date of Birth: _____ MRN #.: _____

With the implementation of Health Insurance Portability and Accountability Act (HIPAA) Winona Health Services must have your specific authorization to share any of your Protected Health Information (PHI) with a spouse or family member.

The type of information: Medical history of diagnostic and therapeutic information, this may include information regarding mental health, developmental disability, HIV, and alcohol and drug abuse, unless otherwise specified. This form DOES NOT authorize the disclosure of any of your written health information.

Verbal communication regarding my treatment can be shared with:

Contact Person	Phone Number	Relationship to Patient
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

This authorization for verbal disclosure of information is effective until such time as I contact my provider.

_____ _____
Patient Signature Date

_____ _____
Parent, Legal Guardian, or Authorized Representative Signature Date

2095A
2/6/2023

PO Box 5600 • 855 Mankato Avenue • Winona, MN 55987 TEL: 507.454.3650 • FAX: 800.944.3960 • winonahealth.org