Hartford HealthCare Medical Group
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6816

Communicating with Family and Friends Form

Request for Verbal Communication of Protected Health Information

Patient Name: _____ Patient Date of Birth: _____

Patient Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Telephone Contact #: Home: ( ) _____ Cell: ( ) _____

Preferred: ☐ Home ☐ Cell ☐ Other: _____

Verbal Sharing of Confidential PHI with Others

By signing below, I give permission for my care team to discuss my (or my child's) protected health information (including diagnosis, diagnostic test results, examination information, claim information, and appointment confirmations) with the individuals specified below when/if these individuals request information on my behalf or if my care team believes it is in my best interest. This permission is specific to my (or my child's) treatment or care at _____.

(Hartford HealthCare Facility or Office)

The purpose of the form is to grant permission for members of my (or my child's) care team to verbally share information with the individuals involved in my (or my child's) care, specified below. Any requests for a releases of written information, such as all information contained in my (or my child's) medical record, will require me to complete and sign a written authorization for Disclosures of Protected Health Information.

I understand that I may revoke this permission at any time. If I want to revoke this permission, I will call the office immediately and complete a new form to restrict future communications to the below individuals.

The above Hartford Healthcare Facility or Office may verbally share patient information regarding my current treatment or care with the individuals listed below.

(1) Name: _____ Relationship: _____ Phone: _____

(2) Name: _____ Relationship: _____ Phone: _____

(3) Name: _____ Relationship: _____ Phone: _____

I have carefully read and understand all of the above. All of my questions have been answered. I understand that my care team may continue to share verbal information with the individuals listed above until I notify the office, in writing, of my decision to change it.

Patient/Legal Representative Signature: _____ Date: _____ Time: _____

Print Name: _____ Relationship to Patient: _____