St Cloud Surgical Center
SPECIALISTS IN OUTPATIENT SURGERY

Authorization to Verbally Discuss Protected Health Information with Family and Friends

Patient Name_____Date of Birth_____

Patient Address_____City_____State____Zip_____

Home/Cell Phone_____Work Phone_____

By signing this form, you authorize St. Cloud Surgical Center teammates to VERBALLY disclose information (e.g. via phone, face-to-face) to the individual(s) you list below. This is separate from your emergency contact(s) and separate from an Authorization for Release of Health Information.

Individual(s) Authorized to Receive Information Verbally:

Name:_____Date of Birth (mm/dd/yyyy):_____

Relationship to Patient: ☐ Parent ☐ Spouse ☐Child ☐ Sibling ☐Other:_____

Name:_____Date of Birth (mm/dd/yyyy):_____

Relationship to Patient: ☐ Parent ☐ Spouse ☐Child ☐ Sibling ☐Other:_____

Name:_____Date of Birth (mm/dd/yyyy):_____

Relationship to Patient: ☐ Parent ☐ Spouse ☐Child ☐ Sibling ☐Other:_____

I authorize St. Cloud Surgical Center to VERBALLY share my information with the family, friends or others that I have listed above as being involved in my health care or payment of my health care. The information to be released may consist of my past, present, or future health information including treatment and billing records.

This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocations must be sent in writing to: St. Cloud Surgical Center, Attn: Medical Records Dept, 1526 Northway Drive, St. Cloud, MN 56303

Information used or disclosed due to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by state and federal law. To make changes or updates to this authorization, a new verbal disclosure authorization form must be completed and submitted to St. Cloud Surgical Center.

The most current version of this form will be retained in the patient's medical record and honored by St. Cloud Surgical Center and its teammates. This authorization will not expire unless revoked in writing by you or your legal representative.

All information below MUST be complete for this form to be valid:

Patient/Legal Representative Signature:_____Date:_____

Printed Name of Person Signing:_____

Relationship of Legal Representative to Patient (if applicable)_____

INTERNAL – ROUTE FORM TO MEDICAL RECORDS