301 Highway 65 South
Mora, MN 55051
320-679-1212

VERBAL AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

Print Patient's Legal Name: _____

Previous Name(s): _____

MR #_____ Birth date: _____/_____/_____

1. PHONE MESSAGES

My care team may leave information on my voicemail or answering at these numbers:

Home: _____ Cell: _____

Work: _____ Other: _____ _____
Name of source

2. PERSON TO PERSON COMMUNICATION

To help with my care or billing, my care team may share information with these people:

Name: _____ _____ _____
First Name, Last Name | Relationship | Contact Number

Name: _____ _____ _____
First Name, Last Name | Relationship | Contact Number

Name: _____ _____ _____
First Name, Last Name | Relationship | Contact Number

Please share:

❒ Scheduling Information ❒ Medical Information ❒ Billing Information

I understand the following:

- This Consent only applies to Welia Health.
- My care team will release all details about treatment for mental health, chemical dependency, sickle cell anemia, genetic conditions and AIDS/HIV.
  If I do not want this information shared, I will write my initials here: _____.
- This form does not expire. If I want to change the information on this form, I will fill out a new form.
- Once information is shared, Welia Health cannot prevent it from being shared with a third party. At that point, it may no longer be protected by privacy laws.
- This form is not intended to release paper records only verbal information. If paper records are intended a
- Release of Information form must be obtained by the patient/ legal representative.

_____
Patient or Legal Representative Signature | Date/Time

_____
Legal Representative Printed Name (if signing for patient) | Authority to sign for patient (attach documentation)