Cameron University

Employee Health Plan

Authorization for Verbal Release of Protected Health Information

Last Name: _____ First: _____ Middle: _____

Other Names Used: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

I _____ give my permission to the University's Health Plan to verbally release information regarding my protected health information from (date) _____ to (date) _____ maintained or created by the Health Plan to the recipient named below.

This Authorization applies to _____ my complete medical record OR _____ my psychotherapy notes OR _____ only this information: _____

Name of Person: _____ Name of Person: _____

Relationship to Member: _____ Relationship to Member: _____

Exceptions: _____ Exceptions: _____

I understand that:

I may revoke this Authorization at any time, in writing. My revocation will not apply to information already retained, used, or disclosed in response to this Authorization. Unless revoked, the automatic expiration date will be 12 months from the date of the signature.

- Unless the purpose of this Authorization is to determine payment of a claim or benefits, the provision of treatment or payment for my care may not be conditioned upon my signing of this Authorization.
- Information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.
- **THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR A NONCOMMUNICABLE DISEASE.**
- The information authorized for verbal release may include protected health information related to mental health. Release of mental health records or psychotherapy notes may require consent of the treating provider or a court order.
- The information authorized for verbal release may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse Member. As a result, by signing below I specifically authorize any such records included in my health information to be released.

_____* _____ _____

Signature of Member, Parent, or Legally Authorized Representative | Relationship to Member | Date

*May be requested to show proof of representative status.