Wayzata Children's Clinic

FACT SHEET - PERMISSION OR AUTHORIZATION TO VERBALLY SHARE YOUR HEALTH INFORMATION

Patients who are 18 years or older & Emancipated Minors: All of your healthcare information is protected.

Minors: Treatment for mental health issues, chemical dependency, family planning or sexually transmitted disease is protected.

Your Privacy Is Important – Your health information is private and Minnesota law gives you control over your medical records.

Most health information needs your consent to be released or shared – We need your **written** consent to talk with your parents or other persons about your health information including your medications and billing. This written consent is helpful also when you are away at college or out of town.

There are specific times that the law allows some health information to be released **WITHOUT** your consent. An example is in a medical emergency or court order. Please ask if you have questions.

Copies of your Medical Record – If you want copies of your medical record, complete our separate "Records Release" form available at all of our clinic sites or on our web page www.wayzatachildrensclinic.com. Feel free to call our Medical Records staff in any of our clinics if you have questions.

You may stop this consent at any time – Just write to the clinic, your Nurse Practitioner or Pediatrician. If the clinic has already released the information based on previous consent, your request to stop will not work for that specific time frame.

If the information is sent to another person or place that you name, the information could be released by that person or place that receives it and may no longer be protected by federal or state privacy laws.

You will NOT be denied treatment or payment of your healthcare bills if you choose not to sign this authorization.

Wayzata Children's Clinic

Consent Form to Verbally Release Health Information

- *Patients who are 18 years or older and Emancipated Minors*
- *Minors receiving treatment for mental health issues, chemical dependency, family planning or sexually transmitted disease.*

Expiration of this Consent – this consent will end one (1) year from the date the form is signed unless you indicate an earlier date or event here.

Patient Information:

First Name:_____ Middle Name: _____ Last Name: _____

Date of Birth:_____ /_____ /_____ Previous Name (if any):_____

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

Your Cell/Daytime Phone:_____Your Email Address:_____

Contact Information – Who can we Talk to?
I give permission for the clinic to talk to the following people:

1. First Name:_____Last Name:_____ about the information indicated below.
   This person can be reached at: Daytime phone:_____ Evening phone:_____
   Relationship to you, the Patient:_____
2. First Name:_____Last Name:_____ about the information indicated below.
   This person can be reached at: Daytime phone:_____ Evening phone:_____
   Relationship to you, the Patient:_____

Indicate the information that you are authorizing us to verbally discuss with the people listed above.
CHECK (Vs) all that apply.

____Specific dates/years of treatment_____

____All health information OR

____Medications ____Mental Health/Behavioral care ____Birth control, family planning or pregnancy

____Immunizations ____Laboratory results

____Chemical dependency or alcohol related care ____Sexually transmitted disease care

____Billing records

____Other Information or Instructions_____

_____

Authorization:

Patient's Signature_____**Date**_____/_____/_____

Continued Authorization: Initials:_____ Date:_____ Initials:_____ Date:_____