North Carolina Specialty Hospital

Permission to Verbally Discuss Protected Health Information with Family and Friends

Patient name (Last, First, MI)	Date of birth	Account #	
Patient street address	City	State	Zip
Home phone	Work phone		

At my request, I give North Carolina Specialty Hospital permission to VERBALLY discuss the following medical and billing information about me (check all boxes that apply):

☐ Scheduling/Appointment information

☐ Billing and payment information

North Carolina Specialty Hospital has my permission to discuss the above information with the following family member, friend or other person. This information is directly relevant to their involvement in my health care (or payment for that care).

1) Name: _____ Phone #_____ Relationship: _____
2) Name: _____ Phone #_____ Relationship: _____

I understand that:

- By signing this Verbal ROI Authorization, North Carolina Specialty Hospital will be permitted to discuss my protected health information identified above with the individuals designated by me above.
- This Authorization is limited to verbal and telephone conversations only and does not authorize the release of written health information to any of the individuals named above.
- I specifically authorize North Carolina Specialty Hospital to verbally release the following sensitive information to the individual named above. Note that Customer Service will not discuss sensitive information.

  ☐ Mental Health · ☐ Substance Use Disorder · ☐ Genetic Testing · ☐ Communicable Diseases
- I may **revoke** this Authorization in writing at any time, except to the extent that action has already been taken in response to this Authorization.
- Information disclosed pursuant to this Authorization may be subject to ***re-disclosure*** by the individuals designated by me above and may no longer be protected by the HIPAA Privacy Rule.
- I understand a photocopy or fax of this form is the same as the original.
- My designation of the individuals above is voluntary. If I do not sign, or if I revoke, this Authorization, North Carolina Specialty Hospital will provide treatment to me and will seek payment for services.
- This Authorization will automatically expire one year from the date signed below unless revoked or another date or event is written here.

Signature of Patient X _____ Date: _____

SEND COMPLETED FORM TO: P.O. Box 15819, Durham, NC 27704-0819 or Fax: 919-287-1600