Permission to Verbally Discuss Protected Health Information with Family and Friends

PATIENT NAME:		DOB:		MRN:			
STREET ADDRESS		CITY:		STATE			
PHONE NUMBER:							

I give permission for NYHTC/HANYC Employee Benefit Funds Health Center Inc. to VERBALLY share the information I have checked with the family, friends or others that I have identified below as being involved in my health care, care coordination or payment of my health care (check all boxes that apply). This form does not authorize releasing copies of my records.

☐ Scheduling/Appointment Information

☐ Medical Information, including my symptoms, diagnosis, medications, and treatment plan

☐ Behavioral health information, including my symptoms, diagnosis, medications, and treatment plan

- ☐ Substance use disorder
- ☐ Developmental disability

☐ Lab/test results ☐ (Check here to include HIV results)

☐ Other (describe):

NYHTC/HANYC Employee Benefit Funds Health Center Inc. 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.

Name _____ Relationship to Patient_____

Name _____ Relationship to Patient_____

Name _____ Relationship to Patient_____

Name _____ Relationship to Patient_____

I understand that in certain situations NYHTC/HANYC Employee Benefit Funds Health Center Inc. may speak to other individuals who are involved in my care or payment of that care, if permitted by law that may not be identified on this form.

I understand that I have the right to revoke my permission at any time except where NYHTC/HANYC Employee Benefit Funds Health Center Inc. has already made disclosures in reliance upon this request. I understand this permission remains in effect until the time I revoke it in writing. If an updated PERMISSION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION WITH FAMILY AND FRIENDS form is received and it has an identical family member/friend/other person listed with updated permissions (different checkboxes), the new version will automatically revoke the previous version on file.

Signature of Patient/Authorized Representative _____ Date _____

If other than patient, state relationship and authority to sign _____

NOTE: For copies of medical records, contact Health Information Management (HIM) department at 718-606-3863 ext. 5595

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We have established a process that allows you to tell us who we may talk with about your health care. This includes appointment and scheduling information, lab and test results, treatment information and billing information.

Where do I send the completed form or any changes?
Please e-mail to HIM@hotelfunds.org, fax the completed form to HIM at 212-237-3008 or return to your closest Health Center.

Note: If you need to obtain copies of your health records, contact Health Information Management at 718-606-FUND (3863) ext. 5595.

How can I give others permission to get verbal information about me?

Complete the Permission to Verbally Discuss Protected Health Information form on the reverse side of this page to let us know to whom we may speak about your information. Check the appropriate boxes to indicate what information we may discuss. You may also send us a letter with this information

Does this mean that you will not speak to anyone I haven't specifically named on the form?

No. If permitted by law, NYHTC/HANYC Employee Benefit Funds Health Center Inc. may speak to other individuals involved in your care (or payment for that care).

How is the information on the form used?

Anytime your designated person calls or makes a request on your behalf, we will verify the individual has your permission to receive the information and then we will share the information.

What are some examples of when this might be useful?

- If an individual wants to share information with spouse or significant other
- If an elderly parent wants an adult child to help understand medical treatment instructions
- If an adult child is helping with billing questions
- If a friend is helping a patient with health issues
- If a college student wants information shared with a parent
- If an adult child calls to find out his/her parent's appointment time

What if I change my mind?

You can change or revoke (stop) this process at any time by writing to us at the address shown above. Forms are available at your clinic, or you can obtain a new form at www.hotelfunds.org. [Of note: If an updated PERMISSION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION WITH FAMILY AND FRIENDS form is received and it has identical family member/friend/other people listed with updated permissions (different checkboxes), the new version will automatically revoke the previous version on file.]

What happens if I don't complete this form?

We will continue to protect your private health information as required by law.

Can the person I designate also get copies of my medical records?

No, they can only receive verbal information. To get copies of medical records, complete a separate Authorization form available by contacting your primary Health Center at the phone number 718-606-FUND (3863), or at www.hotelfunds.org.