KAISER PERMANENTE®
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

Consent to Verbally Disclose Protected Health Information to Family Members and Friends

MEMBER/PATIENT NAME:		
MEDICAL RECORD NUMBER:		
DOB (MM/DD/YYY):	PHONE NO: ( )	
ADDRESS:		
CITY:	STATE:	ZIP CODE:

You have the right to identify family, friends or others involved in your care to verbally receive medical or payment information about you, to help you manage your health care. You may add or change this list at any time. Kaiser Permanente will only share your health information with the individuals you designate, except as required or permitted by law. This consent form does not authorize releasing copies of patient health records, which requires an Authorization for Use or Disclosure of Patient Health Information form.

I consent for Kaiser Permanente to verbally disclose the information I have specified below with the following family, friends, or others who are involved in my health care, care coordination, or payment of my health care:

NAME:	RELATIONSHIP:	PHONE NO:
NAME:	RELATIONSHIP:	PHONE NO:
NAME:	RELATIONSHIP:	PHONE NO:

1. Type of information to be verbally disclosed: (Check all boxes that apply)

☐ ALL information (including psychiatric consults and mental illness, developmental disabilities, genetic testing, HIV/AIDS and test results, sexually transmitted infection, and/or reproductive care if applicable) **excluding substance use disorder information**
☐ Health Plan information (billing, benefits, payments authorizations) including updating demographic and other information
☐ Other (describe):_____

2. I consent that Kaiser Permanente leaving detailed phone messages at the phone number I provided about my medical and health plan information with the following:

☐ Voicemail
☐ Person answering (if listed above)

I understand that I have the right to revoke my permission at any time except where Kaiser Permanente has already made disclosures in reliance upon this request. I understand this consent shall remain in effect until revoked in writing. If an updated CONSENT TO VERBALLY DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS AND FRIENDS form is received and it has an identical family member, friend, or other person listed with updated permissions (different checkboxes), the new version will automatically revoke the previous version on file. If this consent is signed by a minor, it will automatically expire when the minor reaches the age of 18 years old.

X_____ _____
SIGNATURE OF PATIENT/AUTHORIZED INDIVIDUAL DATE

If signed by a personal representative of the patient, please print name below and indicate relationship to patient. For Legal Guardian or Power of Attorney, please submit Legal Documentation with this form.

_____ _____
PRINT AUTHORIZED REPRESENTATIVE NAME RELATIONSHIP TO PATIENT

Please fax the signed document to 855-889-3320 or email to MASHIMSDIT-Scanning@kp.org

2013

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Consent to Verbally Disclose Protected Health Information to Family Members and Friends- Information Sheet

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.

How can I give others permission to get verbal information about me?
Complete the Consent to Verbally Disclose Protected Health Information to Family Members and Friends form to let us know to whom we may speak about your information. Check the appropriate boxes to indicate what information we may discuss.

How is the information on the form used?
Anytime your designated person(s) call or makes a request on your behalf, we will verity the individual has your permission to receive the information and then we will share the information.

What are some examples of when this form might be useful?

- If an individual wants to share information with a 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 speak with their parent's provider regarding their medical treatment

Does this mean that you will not speak to anyone I haven't specifically named on this form?
No. If permitted by law, Kaiser Permanente may speak to other individuals involved in your care (or payment for that care).

What if I change my mind?
You can change or revoke(stop) this permission at any time by writing to us at the address shown below. Forms are available at your clinic, or you can obtain a new form at www.kp.org. (NOTE: If an updated Consent to Verbally Disclose Protected Health Information to Family Members and Friends form is received and it has an identical family member, friend, or other person listed with updated permissions (different checkboxes), the new version will automatically revoke the previous version on file.

What happens if I don't complete the Consent to Verbally Disclose Protected Health Information to Family Members and Friends form?
We will continue to protect your health information as required by law.

Can the person(s) 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 for Use or Disclosure of Patient Health Information form available at your clinic or at www.kp.org.