AUSTIN REGIONAL CLINIC

CONSENT FOR VERBAL RELEASE OF INFORMATION

Patient Name _____ Date of Birth _____ MRN _____

Section A: Complete this section if you are the patient and you are 18+ years of age.

For adult patients, please list the preferred phone numbers to contact you, including the type of number and whether or not you agree to allow Austin Regional Clinic (ARC) physicians, nurses, and other staff to leave PHI on your voicemail:	
Primary Number:	Type: ☐ Home ☐ Work ☐ Cell
Can we leave a detailed voicemail message, including specific test results?	☐ Yes ☐ No
Secondary Number:	Type: ☐ Home ☐ Work ☐ Cell
Can we leave a detailed voicemail message, including specific test results?	☐ Yes ☐ No

Section B: Complete this section if the patient is a minor and you are the parent/legal guardian.

For minor patients, please document the name and preferred number for each parent/legal guardian. and whether or not you agree to allow Austin Regional Clinic (ARC) physicians, nurses, and other staff to leave PHI on your voicemail:	
Name of Parent/Legal Guardian:	Relationship:
Preferred Number:	Type: ☐ Home ☐ Work ☐ Cell
Can we leave a detailed voicemail message, including specific test results?	☐ Yes ☐ No
Name of Parent/Legal Guardian:	Relationship:
Preferred Number:	Type: ☐ Home ☐ Work ☐ Cell
Can we leave a detailed voicemail message, including specific test results?	☐ Yes ☐ No

Section C: Complete this section if you want to authorize any individuals to receive your PHI from ARC.

Please list any person(s) with whom we may share details about your care, including billing information. Indicate whether this may include Sensitive Health Information such as mental health, genetic testing, drug and/or alcohol abuse treatment, and sexually transmitted diseases (STD) including HIV/AIDS.	
Name:	Relationship:
Share Sensitive Health Information? ☐ Yes ☐ No	
Name:	Relationship:
Share Sensitive Health Information? ☐ Yes ☐ No	

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

- ☐ I understand that there are risks involved with leaving protected health information (PHI) on voicemails.
- ☐ I understand that Austin Regional Clinic and its staff cannot guarantee the security and confidentiality of information left on voicemails once delivered.
- ☐ I understand that my physician or other ARC staff will **NOT** leave voicemails relating to: Substance Abuse, AIDS/HIV, Mental Health, Sexually Transmitted Diseases, Pregnancy Results and/or Cancer.
- ☐ I understand that it is my responsibility to inform Austin Regional Clinic if my phone number has changed or if I wish to discontinue this authorization for any reason.
- ☐ I can revoke this consent by completing a new *Consent for Verbal Release of Information* form and returning it to any clinic location.

I have read and fully understand this consent form.

_____ _____ _____

Signature of Patient or Legal Representative | Relationship to Patient | Date