



DukeHealth

**VERBAL RELEASE OF
INFORMATION AUTHORIZATION**



Place Patient Label Here

Patient Name:	Phone:	Email:
Address:		
Date of Birth:	SS# (last 4 digits):	Medical Record #:

At my request, I hereby authorize Duke Health Enterprise (“Duke Health”) to discuss my protected health information identified below, in person or by telephone, with the following individuals:

Name (print)	Phone Number	Relationship
1) _____		
2) _____		

Information to be disclosed (please check one):

- All Information* Related to my Care, Treatment, and Payment (preferred option for Customer Service)
- Billing and Insurance Information
- Clinical Care and Treatment*
- Scheduling/Appointments
- Other (specify): _____

*Does not include sensitive information unless separately approved below

I Understand That

- By signing this Verbal ROI Authorization, Duke Health 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 Duke Health to verbally release the following sensitive information to the individuals 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 **redisclosure** by the individuals designated by me above and may no longer be protected by the HIPAA Privacy Rule.
- My designation of the individuals above is voluntary. If I do not sign, or if I revoke, this Authorization, Duke Health 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

Date