AUTHORIZATION FOR VERBAL COMMUNICATION OF HEALTH INFORMATION. This does not authorize release of copies of medical records - use Krohn Clinic authorization for release of medical records.

1. Patient Information

Name- Last, First Mi		
Street Address		
City	State	Zip code
Medical Record # (if known)	Date of Birth	Phone Number

2. Information to be disclosed: Verbal communication only- no copies of medical records provided.

3. **Communication Between:**
Krohn Clinic ____________ and: Name: ______________________________ DOB: ____________
List first and last name of person (s) to whom your confidential information may be disclosed.

AND/OR

Leave VOICEMAIL at the Following Phone Number(s): ______________________________
______________________________(Voicemail includes any information, unless limited below):

Limit voicemail only to information specified: ______________________________

AND/OR

Leave MESSAGE WITH AN INDIVIDYAL who answers the phone at the number provided above.
Please specify:
☐ Anyone ☐ Name(s) of authorized individual(s) (______________________________)

4. Purpose of Communication: Continued Care, unless specified: ______________________

5. This authorization will expire in one year from signature unless otherwise indicated below:

☐ Indefinite ☐ Ends on (date)______________________________

**** PLEASE SEE PAGE 2 FOR FURTHER INFORMATION****

In accordance with the conditions listed above and on the reverse side of this form, I authorize disclosure of my medical information. This authorization includes disclosure of information regarding psychiatric consults, mental illness, developmental disabilities, alcohol or drug treatment, AIDS or AIDS-related illness, and/or HIV test results (if applicable) unless I limit discussion to exclude the following medical conditions: ______________________
____

Signature of Patient/Representative: ______________________________Date:____________

If signed by person other than the patient, print name and state relationship and authority to do so. (See reverse side for information about signatures)

Print name: ______________________________ Relationship: ____________________

Patient is: ☐ Minor ☐ Incompetent/Incapacitated ☐ Legal Guardian

☐ Parent of Minor ☐ Health Care Agent ☐ Other

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ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT MEDICAL INFORMATION

Krohn Clinic honors a patient's right to confidentiality of medical information as provided under federal and state law. Please read the following guidelines before signing this authorization.

Sending authorizations to Krohn Clinic: If mailing an authorization, please mail to the following address:

Krohn Clinic LTD
Attention: Release of Information
610 West Adam Street
Black River Falls, WI 54615

Verbal Communication Only. This authorization allows for verbal communication (both in person and on the telephone) between Krohn Clinic and the designated person(s) on the form. It does not allow for copies of medical records to be released.

Voice Mail Messages: To protect your confidentiality, Krohn Clinic providers and staff will not routinely leave messages on your personal messaging system (voicemail, answering machine, a spouse or any other individual) unless you specifically give your permission to do so. This authorization may be used to share this information in the manner you specify.

No Obligation to sign: You are not under any obligation to sign this form, and you may refuse to do so. Except as permitted under applicable law, Krohn Clinic may not refuse to provide you treatment or other health care services if you refuse to sign this form.

Revocation: You have the right to revoke this authorization, in writing, and any time before it ends. However, your written revocation will **not** affect any disclosures of your medical information that they person(s) or organization(s) listed on page 1 of the form have already made, in reliance on this authorization, before the time you revoke it. Your revocation must be in writing or faxed to the address below:

Krohn Clinic LTD
Attention: Release of information
610 West Adam Street
Black River Falls, WI 54615

Or faxed to (715) 284-0475

Re-release: If the person(s) and/or organization(s) authorized by this form to receive your medical information are not health care providers or other people who are subject to federal healthy privacy laws, the medical information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release your medical information without your permission.

Signatures: Generally, if you are 18 years of age or older, you are the only person who is permitted to sign this form to authorize the disclosure of your medical information. If you are under the age of 18, your parent or guardian must sign this form for you. For more information regarding who is authorized to sign this form, contact Release of Information at the Krohn Clinic at (715) 284-1829.