Morton Rural Health Clinic
(806) 266-5566

Consent to Verbally Discuss Protected Health Information

Cochran Memorial Hospital and Clinic
EST. 1947

Complete form using blue or black ink only. All sections must be completed.

Patient Name		MR#
DOB	Phone	
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 to or change this list at any time. Morton Rural Health Clinic 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 to Release Confidential Information* form.

I consent for Morton Rural Health Clinic 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

1. Type of information to be verbally disclosed: *Check all 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.**

☐ Substance use disorder information

☐ Health Plan Information (billing, benefits, payment authorizations) including updating demographic and other information.

☐ Other (describe)_____

2. I consent that Morton Rural Health Clinic may leave detailed phone messages at the phone number I provided about my medical and health plan information with the following: *Check all that apply*

☐ Voicemail

☐ Person answering, if listed above.

I understand that I have the right to revoke my permission at any time, except where Morton Rural Health Clinic has already made disclosures in reliance upon this request. I understand this consent shall remain in effect until revoked in writing or for one year from the date signed below. If signed by a legal guardian or power of medical attorney, legal documentation of such must be submitted to Morton Rural Health Clinic.

Signature of Patient/Authorized Representative	Date
Print Name	Relationship to Patient