OLMSTED MEDICAL CENTER

Authorization for Allowing Verbal Communication of Protected Health Information

For OMC Staff Use Only:

Patient MR#: _____

Print Legal Name of Patient

Date of Birth

Street Address

Phone Number

City, State, Zip Code

I permit Olmsted Medical Center, their physicians, nurses, and other personnel ("OMC Healthcare Providers") to discuss health information, in person or by telephone, with the following person involved in my medical care:

Name and Relationship

Phone Number

This Authorization is limited to DISCUSSIONS regarding the following medical condition(s):

(If no limitations are listed, discussions will be permitted regarding any medical condition and/or billing for which the patient has received care at Olmsted Medical Center.)

I understand that this authorization is valid for one year from the date signed or for the time period specified here:

From: _____ To: _____ (actual dates required).

Release of information under this document is limited to verbal discussions with my OMC Healthcare Providers. This document does not permit release of any written health information to the individuals named on this authorization.

If, at any time, I do not want verbal discussions to be permitted between my OMC Healthcare Providers and the person listed on this authorization, I must notify my OMC Healthcare Provider in writing.

Patient's Signature: _____ **Date:** _____

If this authorization is being completed by a representative on behalf of the patient, please complete the following:

Representative's PRINTED Name: _____

Relationship to Patient/Authority (please submit legal documentation): _____

Signature: _____ Date Signed: _____

INSTRUCTIONS: Please print, sign and return completed form to:

Olmsted Medical Center
Attn: Release of Information
1650 Fourth Street SE, Rochester, MN 55904
Fax: 507.287.2777

Translated Versions – Consent – Authorization for Allowing Verbal Communication of PHI
English – 1031908 Spanish – 2022819 Somali – 2030119