FEMALE HEALTH ASSOCIATES OF NORTH TEXAS

Permission to Verbally Discuss Protected Health Information with Family and Friends

—Completion of this form is optional—

If you, the patient chooses not to authorize an agent to discuss please check the box. ☐

Patient Name:	Date Of Birth:	Phone Number:
Home Address:	City/ Zip Code:	

I give permission for Female Health Associates of North Texas to VERBALLY share the information I have checked with the family, friends, or others that I have identified below as being involved in my health care, care coordination or payment of my health care. (check all boxes that apply) **This form does not authorize releasing copies of my records.**

- ☐ Scheduling/Appointment information
- ☐ Medical Information, including my symptoms, diagnosis, medications, and treatment plan.
- ☐ Behavioral health information, including my symptoms, diagnosis, medications, and treatment plan Substance use disorder Developmental disability.
- ☐ Lab/test results **-including HIV results. YES/ NO (circle one)**
- ☐ Billing and payment information
- ☐ Other (describe):_____

Female Health Associates of North Texas has my permission to discuss the above information with the following family member, friend, or other person. This information is directly relevant to their involvement in my health care (or payment for that care).

Name/ Date of Birth:	Name/ Date of Birth:
Phone Number:	Phone Number:
Address:	Address:

I understand that in certain situations Female Health Associates of North Texas may speak to other individuals who are involved in my care or payment of that care, if permitted by law, that may not be identified on this form.

I understand that I have the right to revoke my permission at any time except where HealthPartners has already made disclosures in reliance upon this request. I understand this permission remains in effect until the time I revoke it in writing. If an updated PERMISSION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION WITH FAMILY AND FRIENDS form is received and it has an identical family member/friend/other person listed with updated permissions (different checkboxes), the new version will automatically revoke the previous version on file.

Signature of Patient/Authorized Representative: X_____ **Date:**_____

If other than patient, state relationship and authority to sign:_____

NOTE: For copies of medical records, contact *Female Health Associates of North Texas at 817-731-3936 or www.femalehealthassocaites.com*