

Authorization to Verbally Discuss Health Information Form
Who can Discuss your Health Information?

Patient Name: _____ Date of Birth: _____

IMPORTANT – PLEASE READ

- This form allows Promise Healthcare to **verbally discuss** health information in person or by telephone only.
- This form does **NOT** authorize release of written medical records. A Release of Information (ROI) form would be required to release written records.
- **Illinois law gives minors ages 12–17 the right to control certain health services.**
- Promise Healthcare follows HIPAA and Illinois law regardless of who signs this form.

Please note: This form includes a **second page**, which must be reviewed. Certain types of **sensitive health information require additional consent** and are addressed on page 2.

Listing someone on this form does not automatically allow disclosure of all health information. Under **Illinois law**, patients ages **12–17** have the right to consent to certain services, and **the minor patient’s consent may be required**, even if a parent or guardian is listed or has signed. More information on page 2

I do **NOT** authorize Promise Healthcare to discuss my health information with anyone.

The people that can have my Health Information:

1. Name:			Relationship to you:		
Phone #:		Street Address:			
City:		State:		Zip Code:	
2. Name:			Relationship to you:		
Phone #:		Street Address:			
City:		State:		Zip Code:	
3. Name:			Relationship to you:		
Phone #:		Street Address:			
City:		State:		Zip Code:	

APPROVED TYPES OF INFORMATION:

Check all that apply (subject to legal restrictions)

Billing Information	Appointment Information	Lab Results or diagnostic Testing results	Treatment Information
Dental Services	Other (Specify): _____ _____ _____		All Information legally permitted

SENSITIVE HEALTH INFORMATION – ADDITIONAL CONSENT REQUIRED

I understand that the information approved above may include **sensitive health information** that requires **specific authorization** before it may be discussed. By initialing and dating each item below, I authorize Promise Healthcare to verbally discuss the selected sensitive topics with the individuals listed on this form, **only as permitted by federal and Illinois law.**

Important: Selecting “All Information” on previous page does not authorize disclosure of sensitive information unless the applicable item below is initialed and dated and disclosure is permitted by law.

Illinois Minor Consent: When Illinois law allows a minor to consent independently to a service, **only the minor may authorize disclosure** of information related to that service.

For minors ages 12–17, minor authorization (initials and signature) is required to discuss information related to *(list not all-inclusive)*

- Drug or alcohol use or treatment
- Reproductive health care
- HIV/AIDS and sexually transmitted diseases (STDs/STIs)
- Outpatient counseling or therapy services
- Any care provided under the minor’s independent legal consent

When parental consent is permitted by law, a **parent or legal guardian may authorize disclosure**, subject to legal restrictions.

Please select all additional sensitive information you wish to release. In order to be released it must have initial and date.

**For patients 12-17, the items marked with an asterik (*) may require the minor patients’s authorization if selected for release.*

Mental/Behavioral Health

- **Psychiatric / Mental Health Treatment**
(e.g., psychiatric diagnosis, psychiatric appointments, medication management, inpatient or intensive treatment)
Initials: _____ Date: _____
- ***Counseling / Therapy Services** *(e.g., outpatient counseling)*
Initials: _____ Date: _____

*Alcohol/Drug Abuse Initials: _____ Date: _____

Genetics Initials: _____ Date: _____

*Reproductive Care Initials: _____ Date: _____

*HIV/AIDS/Sexually Transmitted Disease Initials: _____ Date: _____

Authorization Signatures

By signing below, I acknowledge that I have read and understand this authorization. I understand that this authorization allows **verbal discussion only** of the health information identified above, **only as permitted by federal and Illinois law.**

I understand that disclosure:

- Depends on **who has legal authority to consent** for the service
- For Minors: Requires the **minor’s signature** when Illinois law allows a minor (ages 12–17) to consent independently and **may not be authorized by a parent or guardian** for services subject to minor consent rights. Promise Healthcare requires an **adult witness** (non parent) when the patient is a minor (ages 12–17).

Patient / Parent / Legal Guardian Signature

Signature: _____ Date: _____
Printed Name: _____ Relationship to Patient (if applicable): _____

Minor Patient Signature *(required when the minor independently consented to the service)*

Signature: _____ Minor Initials: _____ Date: _____
Printed Name: _____

Witness (Required for Minors Ages 12–17)

Signature: _____ Date: _____
Printed Name: _____ Relationship to patient: _____ Phone #: _____

This authorization remains valid while the patient is receiving services at Promise Healthcare unless an earlier expiration date is specified or the authorization is revoked in writing. If multiple versions of this form are completed, **only the most recent signed version is valid.** If the patient is a minor at the time of signature, this authorization **expires when the patient reaches the age of majority (18yo) or emancipated.**