RELEASE OF VERBAL INFORMATION (SENSITIVE)

TRINITY HEALTH

I, _____, _____ give my consent to allow Trinity Health to
(patient name) (date of birth)
speak with the following people or facilities.

OR

I, _____, representing _____, _____
(patient designee) (patient name) (date of birth)
give my consent to allow Trinity Health to speak with the following people or facilities.

My relationship to the patient is that of *(please circle one)*: Parent of Minor Child, Legal Guardian, (paperwork required)
Power of Attorney or Other_____.
(paperwork required) (other relationship)

1._____
Phone #:_____
- ☐ Acknowledge Presence
- ☐ Schedule Appointments
- ☐ Verbal Release – Chemical Dependency (would include Alcohol & Drug related information)
- ☐ Verbal Release – Mental Health (would include Riverside, CAPH, and Psych information)

2._____
Phone #:_____
- ☐ Acknowledge Presence
- ☐ Schedule Appointments
- ☐ Verbal Release – Chemical Dependency (would include Alcohol & Drug related information)
- ☐ Verbal Release – Mental Health (would include Riverside, CAPH, and Psych information)

3._____
Phone #:_____
- ☐ Acknowledge Presence
- ☐ Schedule Appointments
- ☐ Verbal Release – Chemical Dependency (would include Alcohol & Drug related information)
- ☐ Verbal Release – Mental Health (would include Riverside, CAPH, and Psych information)

4._____
Phone #:_____
- ☐ Acknowledge Presence
- ☐ Schedule Appointments
- ☐ Verbal Release – Chemical Dependency (would include Alcohol & Drug related information)
- ☐ Verbal Release – Mental Health (would include Riverside, CAPH, and Psych information)

I understand that information disclosed under this Authorization could be redisclosed by the recipient and Trinity Health is not responsible. However, the recipient is held to all standards set in all aspects of Federal Regulations 42 CFR, Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records. The federal privacy rules may not protect my health information once the recipient rediscloses it.

I understand that this consent form authorizes release of verbal information and is valid for a **maximum** of one (1) year from the signature date below unless a prior alternate date is completed. I have the right to revoke this consent or change the list of people authorized by this consent form at any time with written notification to Trinity Health.

_____ _____ _____
Signature (NOTE: For Addiction Services, 14 years old or older is considered an adult) Date Time

_____
Alternate Expiration Date

_____ _____ _____
Representative Date Time

SD105

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PATIENT LABEL