Bigfork Valley
Hospital • Clinics • Communities
P.O. Box 258, Bigfork, Minnesota 56628

Authorization to Discuss Protected Health Information

Print patient's legal name: _____ *(Office use only: MR#_____)*

Birth date: ____/____/____ Previous names: _____

---

1. Phone Messages

My care team may leave information on my voicemail or answering machine at these numbers:

Home: _____ Cell:___ _____ Work: _____

Please share:

☐ Scheduling information ☐ Medical information ☐ Billing information ☐ Nothing

2. Communication (in any format – verbal, paper, etc.)

To help with my care or billing, my care team may share information with these people:

_____ _____	_____	_____
First name, Last name	*Relationship to me*	*Best contact number*
_____	_____	_____
First name, Last name	*Relationship to me*	*Best contact number*
_____	_____	_____
First name, Last name	*Relationship to me*	*Best contact number*

Please share:

☐ Scheduling information ☐ Medical information ☐ Billing information ☐ Nothing

---

I understand the following:

- This consent applies to Bigfork Valley Hospital, Clinics and Communities.
- My care team will release all details about treatment for mental health, chemical dependency, sickle cell anemia, genetic conditions and AID/HIV. **If I do not want this information shared, I will write my initials here: _____.**
- This form does not expire. If I want to change the information on this form, I will fill out a new form.
- Once information is shared, Bigfork Valley cannot prevent it from being shared with a third party. At that point, it may no longer be protected by privacy laws.

_____ _____

Signature of patient or authorized representative *Date*

If signing as the authorized representative of the patient, I am: (please check one)

☐ the court appointed guardian or conservator of the patient (Legal Documentation Required)
☐ a custodial parent of a minor
☐ other (specify): _____

Identification of Requestor Verified? ☐ Method: _____ Verified by: _____