BSA Physician's Group, Inc
1600 Wallace Blvd
Amarillo, TX 79106

VERBAL DISCLOSURE
BSA 1348 12-2020

PATIENT NAME: ______________________________________ MRN:_______________________________________

DATE OF BIRTH: ______________________________________

In accordance with the provisions of Section 164.510(b) of the Health Insurance Portability and Accountability Act (HIPAA), I agree that BSA Health System and its duly authorized agents and employees may disclose Protected Health Information directly relevant to involvement with my care, or payment related to my care, to my family members, other relatives, close personal friends or any other individuals that I indicate below who may contact BSA Health System on my behalf.

NAME OF INDIVIDUAL(S) AND RELATIONSHIP: (Please print)
Check the box next to the name to identify the type of information to be disclosed

☐ Medical ☐ Billing ____

☐ Medical ☐ Billing ____

☐ Medical ☐ Billing ____

I understand:

- At any time, I may add or remove individuals from this list by notifying BSA Health System of my desire to do so. I understand that until I notify BSA Health System of requested changes to this list, BSA Health System may rely on this list and disclose information the individuals listed above.
- The authorization to release information to the parties listed above is good for one year from the date below unless you tell us otherwise.

NOTICE OF RIGHTS: Information in your medical records that you have or may have a communicable or non-communicable disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances *including* disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court or the Department of Health, disclosure among healthcare providers or for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified. I understand that my medical information may indicate that I have or have not been treated for psychological or psychiatric conditions or substance abuse.

____ ____________________
SIGNATURE OF PATIENT DATE

____ ____________________
SIGNATURE OF PATIENT REPRESENTATIVE DATE

____
DESCRIPTION OF REPRESENTATIVES AUTHORITY TO ACT FOR THE PATIENT

REVOCATION OF VERBAL DISCLOSURE

I may revoke this permission at any time, in writing, except revocation will not apply to information already disclosed in response to this permission.

____________________________________ ________________________
Patient/Patient Representative Signature Date Signed/Revocation