M20UP-044
Rev. 6/24

DukeHealth

VERBAL RELEASE OF INFORMATION AUTHORIZATION

Place Patient Label Here

Patient Name:	Phone:	Email:
Address:		
Date of Birth:	SS# (last 4 digits):	Medical Record #:

At my request, I hereby authorize Duke Health Enterprise ("Duke Health") to discuss my protected health information identified below, in person or by telephone, with the following individuals:

Name (print) **Phone Number** **Relationship**

1) ______________________________

2) ______________________________

Information to be disclosed (please check one):

All Information* Related to my Care, Treatment, and Payment (preferred option for Customer Service)
Billing and Insurance Information
Clinical Care and Treatment*
Scheduling/Appointments
Other (specify):______________________________

*Does not include sensitive information unless separately approved below

I Understand That

- By signing this Verbal ROI Authorization, Duke Health will be permitted to discuss my protected health information identified above with the individuals designated by me above.
- This Authorization is limited to verbal and telephone conversations only and does not authorize the release of written health information to any of the individuals named above.
- I specifically authorize Duke Health to verbally release the following sensitive information to the individuals named above. Note that Customer Service will not discuss sensitive information.
  ☐ Mental Health ☐ Substance Use Disorder ☐ Genetic Testing ☐ Communicable Diseases
- I may **revoke** this Authorization in writing at any time, except to the extent that action has already been taken in response to this Authorization.
- Information disclosed pursuant to this Authorization may be subject to ***redisclosure*** by the individuals designated by me above and may no longer be protected by the HIPAA Privacy Rule.
- My designation of the individuals above is voluntary. If I do not sign, or if I revoke, this Authorization, Duke Health will provide treatment to me and will seek payment for services.
- This Authorization will automatically expire one year from the date signed below unless revoked or another date or event is written here: ______________.

______________________________ ______________________________
Signature of Patient Date

SEND COMPLETED FORM TO: ROI-requestor3@dm.duke.edu; Fax: 919-620-5165 OR
Duke University Hospital - HIM P.O. Box 3016 Durham, NC 27710; For Questions Call: 919-684-1700