Ryon Medical & Associates, LLC
318 Lacey Ave
La Junta, CO 81050
(719)384-0303 Ph ~ (719)384-1033 Fax

Permission to Verbally Discuss Protected Health Information

-Completion of this form is optional-

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

Verbal Communication:

I give permission to Ryon Medical & Associates, LLC to VERBALLY discuss the following medical and billing information about me (check all boxes that apply):

- ❒ Scheduling/Appointment information
- ❒ Medical information, including symptoms, diagnosis, medications and treatment plan
- ❒ Behavioral health information, including my symptoms, diagnosis, medications and treatment plan
- ❒ Sensitive health information for conditions of sexually transmitted diseases
- ❒ Chemical dependency information containing drug and alcohol treatment, including my symptoms, diagnosis, medications and treatment plan
- ❒ Lab/test results
- ❒ Billing and payment information
- ❒ Leave of Absence (specify): _____
- ❒ Other (describe): _____

Ryon Medical & Associates, LLC has my permission to discuss the above information with:

First name, last name	*Relationship to me*	*Best contact number* **Phone Messages:**

I give permission to Ryon Medical & Associates, LLC to leave the following information on my voicemail or answering machine at the phone numbers indicated.

❒ Scheduling/Appointments ❒ Medical information ❒ Billing information ❒ Nothing

Home phone	*Cell phone*	*Work phone*

- I understand that I may revoke this authorization, in writing, at any time except to the extent that Ryon Medical has already relied on this authorization.
- I understand that I may revoke this authorization by sending or faxing a written notice to the Medical Records 318 Lacey Ave, La Junta, CO 81050 or fax (719) 384- 1033.
- I understand that Ryon Medical may not condition treatment, payment/enrollment or eligibility for benefits on the completion of this authorization form.
- I understand that information being disclosed may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Law/ if the recipient is not a "covered entity".

Unless otherwise revoked, this Authorization shalt be in force and effect indefinitely or expires _____ from the date of signature.

By signing below, I agree that I have reviewed and I understand this authorization.

By: _____ Date: _____

Patient Signature

OR

By: _____ Date: _____

Patient Representative

Relationship to patient: ❒ Legal guardian* ❒ Holder of Power of Attorney* ❒ Parent of minor child *Please attach legal documentation if you are the legal guardian or Holder of Power of Attorney

Office Use Only:

Date entered in EMR:

_____

Initials:

_____