St. Charles HEALTH SYSTEM

AUTHORIZATION FOR ST. CHARLES TO SPEAK WITH PATIENT DESIGNATED LAY CAREGIVER

Patient Label

Patient Name: _____ Date of Birth:_____/_____/_____

Address:_____ City:_____ State:_____ Zip:_____

Phone: _____

Purpose of this consent is to allow St. Charles Caregivers to have verbal communication with the patients' designated lay caregiver. For release of medical records, please use Authorization for Use and Disclosure of Protected Health Information - English or Authorization for Use and Disclosure of Protected Health Information - Spanish.

NOTE: please use one form per designee.

Name	Relationship to patient	Phone

Your health information may contain information that is considered sensitive, and is specially protected by federal privacy law. Specially protected information includes: HIV results, behavioral health, genetic testing, and alcohol or drug abuse information. If you choose to authorize SCHS caregivers to speak to the designee above, this information may be shared. By signing this authorization form, I understand that:

- I have the right to revoke (take back or change my mind about) this authorization at any time. Contact the SCHS Privacy Office to request the HIPAA Restriction Request form, privacyofficer@ stcharleshealthcare.org
- If I ask to revoke an authorization that was signed by me on a previous date, the request to revoke will not apply to information that has already been shared / discussed as a result of the original request.
- No determination about treatment, payment, enrollment, or eligibility for benefits will be based on whether or not I sign this authorization form.
- I understand that federal confidentiality rules will not protect the medical information that I have authorized to be shared, if it is shared again by the organization or person that receives it.
- The benefits of a lay caregiver information sheet have been provided and explained to me. I understand that only the minimum information necessary will be shared in support of safety and discharge planning.

This authorization will expire one year from the date it is signed.

_____ _____
Patient or Authorized Representative Signature Date / Time

_____ _____
Printed Name Relationship to Patient (if applicable)

(For Office Use Only)

Name of Caregiver Accepting Authorization:_____ Department:_____

St. Charles Health Information Management | 2500 NE Neff Road, Bend, OR 97701 | Phone: 541-706-7784

Note: This form is a permanent part of the medical record.

The benefits of a lay caregiver information sheet have been provided to the patient. All attempts to obtain authorization for SCHS to speak with a designated lay caregiver for the patient have been unsuccessful.

_____ _____
Name of Caregiver Date / Time

_____
Witness

* 1 R O I *