

*Insights, Inc*  
703 N. 8th Street, Suite 202  
Sheboygan, Wisconsin 53081

Authorization for Oral Disclosure of Patient Health Information to Family or Friends - HIPAA

\_\_\_\_\_

do hereby consent to authorize *Insights, Inc* to disclose patient health information orally relating to my identity, diagnosis, prognosis or treatment to the individuals listed below.

INDIVIDUALS TO WHOM ORAL DISCLOSURE OF PATIENT HEALTH INFORMATION MAY BE MADE:

- |          |                         |       |
|----------|-------------------------|-------|
| 1. _____ | _____                   | _____ |
| Name     | Relationship to Patient | Phone |
| 2. _____ | _____                   | _____ |
| Name     | Relationship to Patient | Phone |
| 3. _____ | _____                   | _____ |
| Name     | Relationship to Patient | Phone |

DURATION OF AUTHORIZATION / EFFECT OF REVOCATION:

I understand that unless revoked in writing, this authorization will remain in effect for \_\_\_\_\_ years (to be completed by patient) from the date set forth below. If the number of years is left blank, this authorization will expire 2 years from the date signed.

I also understand that this authorization cannot be revoked in part. If I revoke my authorization as to one or more individuals listed, this entire authorization shall be null and void, and I have the option of executing a new authorization form at such time.

\_\_\_\_\_  
Client/Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date