181

OLYMPIC MEDICAL CENTER

AUTHORIZATION TO VERBALLY DISCLOSE PROTECTED HEALTH INFORMATION

OLYMPIC MEDICAL PHYSICIANS

Olympic Medical Center realizes that there may be times when you, the patient, may want another person to be knowledgeable about your medical condition or medical needs. If so, your authorization allows staff to speak with the individual(s) you designate below.

PATIENT INFORMATION:

Patient Name (printed):_____ Previous Name (if any):_____

Date of Birth:_____ Daytime Telephone Number:_____

INFORMATION TO BE DISCLOSED FROM:

I hereby authorize Olympic Medical Center to verbally disclose the following information contained in my medical record and/or information regarding my medical care or condition as described below.

GENERAL INFORMATION TO BE DISCLOSED TO PEOPLE NAMED BELOW:

- ❑ You may discuss scheduling and appointment information.
- ❑ You may discuss test results, medical condition(s) and/or current treatment.
- ❑ You may discuss billing, insurance and payment information.

INFORMATION TO BE DISCLOSED TO:

Name	Relationship to Patient	Phone Number

DISCLOSURES REQUIRING SPECIAL CONSENT:

My signature below specifically authorizes the disclosure of healthcare information relating to the testing, diagnosis, or treatment for (Please initial beside the specific information to disclose):

_____Drug and Alcohol Abuse / Treatment

_____Mental Health / Psychiatric Disorders

_____HIV / AIDS Virus

_____Sexually Transmitted Infections

_____Reproductive Health

CONSENT TO DISCLOSE:

By my signature below I indicate that I understand that I have the right to revoke this authorization in writing at any time. I understand that information used or disclosed pursuant to this authorization may be further disclosed by the recipient and may no longer be protected by federal or state law.

<u>This consent is specific to verbal disclosures only.</u> If copies of my medical records are being requested, a separate Authorization to Disclose Protected Health Information will need to be obtained.

This authorization will be valid for 90 days or until:_____

_____ _____ OR _____❑ Patient verbally agreed

Date Signature of patient or representative Witness Signature for Verbal Agreements