Standing Authorization to Verbally Disclose My Heath Care Information

We are required by law to maintain the privacy of your PHI "Protected Health Information." PHI includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the healthcare you have received, or payment for your health care.

You do have the right to restrict and limit the use and disclosure of your PHI to designated party(ies) of your choosing. Please review our NPP (Notice of Privacy Practices) for additional uses and disclosures of your PHI without your written consent.

Patient's name: _____Date of Birth: _____/____/_____ACCT#_____
To be filled out by Steck Medical

My Authorization
I authorize L.G. Steck Memorial Clinic, PS, and its business associates verbally disclose the following health care health information.
(***check all that apply***)

☐ All healthcare information in my medical record.
☐ Health care information in my medical record related to the following treatment or condition.
_____
☐ Health care information in my medical record for date(s):_____
☐ Financial health information only

The following items must be **checked** and **initialed** to be included in this request for use and disclosure:
You may verbally disclose health care information regarding testing, diagnosis, and treatment for:

☐ HIV/AIDS related information _____
☐ Mental health information _____
☐ Drug & alcohol treatment information _____
☐ Sexually transmitted diseases _____

Designated Party(ies)_____ Relationship to Patient_____ Phone:_____

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My rights:
The patient or the patient's representatives must read the following statements:

1. I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). I also understand that this authorization **only covers verbal disclosers.** Washington State law (RCW 70.02) requires that a written authorization be signed for release of PHI other than verbal disclosers, and a written authorization of that type is **only valid** for 90 days
2. I understand that this authorization will: (***Must check one***)
   ( ) expire 1 year from the date signed by the patient or the patient's representative; or
   ( ) be effective for the lifetime of the patient unless revoked (see #3 below)
3. I understand that I may revoke this authorization at any time by notifying L. G. Memorial Clinic, PS, **in writing**; however, if I do revoke the authorization, it will not have any effect on any actions taken by L.G. Steck Memorial Clinic, PS, prior to their receipt of the revocation.
4. I understand that my treatment cannot be conditioned on whether I sign this authorization.

_____ _____
Signature of patient or patient's representative **Date**
(Form MUST be completed before signing or will not be valid)

Printed Name of Patient's Representative: _____

Relationship to Patient: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION