

Standing Authorization To Verbally Disclose My Health Care Information

Patient name: _____ Date of birth: _____

I. My Authorization

You may verbally disclose the following health care information (check all that apply):

- ☐ All health care information in my medical record
- ☐ Health care information in my medical record relating to the following treatment or condition:

☐ Health care information in my medical record for the date(s): _____

You may verbally disclose health care information regarding testing, diagnosis, and treatment for:

- ☐ HIV (AIDS virus) ☐ Sexually transmitted diseases
- ☐ Psychiatric disorders/mental health ☐ Drug and/or alcohol use

You may verbally disclose this health care information to:

Name: _____ Relationship: _____

Phone Number: _____

☐ And no others

Name: _____ Relationship: _____

Phone Number: _____

☐ And no others

Name: _____ Relationship: _____

Phone Number: _____

☐ And no others

Reason(s) for this authorization (check all that apply):

- ☐ at my request ☐ other (specify) _____

This authorization:

- ☐ ends on (date): _____ ☐ ends 90 days from today's date

II. My Rights

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 disclosures. Washington State law (RCW 70.02) requires that a written authorization be signed for releases of protected health information other than verbal disclosures. I may revoke this authorization in writing. If I do, it will not affect any actions already taken based upon this authorization. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship (parent, legal guardian, personal representative)