Central WASHINGTON HOSPITAL PHYSICIANS

PHYSICIAN CLINICS

AUTHORIZATION TO SHARE MEDICAL INFORMATION

Your Right to Medical Information Confidentiality

HIPAA is an acronym that stands for the **H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct that was made into law in 1996. By law, if you are 18 years or older, you have the right to strict confidentiality regarding your visits to any of our CWH Physician Clinics. In order to release any information including the date or nature of your visit, CWH must have your signed consent and specific directions about what information you are consenting to be released. Without written consent, we cannot release or discuss information relating to your visit with anyone including your parents, children, guardians, spouse, employer and coach.

In addition, you have the right to revoke this authorization at any time, and it will be effective when any of our CWH Physician Clinics receive your written revocation. A copy of this authorization will be kept in your CWH clinic health record. The information disclosed under this authorization might be redisclosed by a recipient and may as a result of this disclosure, no longer be protected to the same extent as this information was protected by law while solely in the possession of CWH Physician Clinics.

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Patient's Name (Please Print)_____ Date of Birth_____

In signing this authorization to release my protected health information I acknowledge that I have read and understand my rights to medical confidentiality and authorize CWH Physician Clinics to discuss health issues regarding:

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With the following individuals only:

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

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Signature_____ Date_____

CWH Physician Clinic Staff_____ Date_____