WASHINGTON HEALTH SYSTEM

Washington Health System Physician Offices
HIPAA Communication

Patient Name: _____ Date of Birth: _____

I give permission to the staff of Washington Health System Physician Offices to communicate with the approved individual(s) below, regarding my medical care, including my medical condition, test results, and appointment dates/times.

Check (X) the box for all Practices this applies to.	ALL	PCP Office	General Surgery	Washington Pediatrics	OB/GYN Care	Center for Mental Health and Wellbeing	Cardiovascular Care	Center for Orthopedic Excellence	Infectious Disease	Pulmonary/ Critical Care	Urology
Authorized Contact: _____ Relationship: _____ Phone #: _____											
Authorized Contact: _____ Relationship: _____ Phone #: _____											
Authorized Contact: _____ Relationship: _____ Phone #: _____											

I give my permission for WHS Physician Offices to contact me in the following methods:

☐ Phone Phone/text messages may include important health services and appointment reminders.
☐ Text Message Please check preferred number for staff to contact.

☐ Home #: _____ ☐ Cell #: _____

☐ Patient Portal: Secure online communication where you can send and receive messages to your providers and office staff. You will receive an email reminder for upcoming appointments and notifications when WHS test results and other information are available. You can retrieve messages by logging on to the secure portal or by using the HEALOW app.

Email address: _____

I understand that is my responsibility to notify WHS Physician Office(s) where I am receiving care if any of the above information changes.

Patient or Authorized Signature/Relationship: _____
Date: _____

Patient unable to sign due to: ☐ Mental Incompetency ☐ Physical Inability ☐ Under 18 ☐ Other _____