Name – First/MI/Last (Please print)		
Street Address		
City	State	Zip
Date of Birth	Phone Number	

I, _____ , authorize MultiCare, their physicians, nurses, and other personnel to discuss all health and payment information unless specific dates of service and/or conditions treated are described here:

_____ ,

in person or by telephone, with the following **individuals directly involved in my medical care.**

Name (Please print)	**Phone Number**	**Relationship**
1)		
2)		
3)		
4)		

I authorize the inclusion of the following information: (Initial all that apply) See reverse side for details

_____ HIV (AIDS virus) _____ Sexually transmitted diseases _____ Genetic information and indicators

_____ Psychiatric diagnosis or mental health _____ Substance use disorder

I UNDERSTAND THAT THIS AUTHORIZATION IS:

- **Limited** to verbal and telephone conversations and does not permit or authorize the release of any **written health information** to any of the individuals named above.

Once MultiCare discloses your health information, the recipient may re-disclose the information, and privacy laws may no longer protect your information. Federal and state laws may forbid sharing information about substance use disorders, sexually transmitted diseases, or mental health information without written consent of the patient.

I further understand that if I do not want verbal discussions to be permitted between my health care provider and any of the individuals named above I have the right to revoke this authorization, in writing, at any time. I understand that this written revocation will not affect any disclosures of my medical information that the person(s) and/or organization(s) listed on this authorization have already made, in reliance on this authorization, before the time I revoke it.

MultiCare will not condition treatment, payment, and enrollment or benefit eligibility on my signing this document. This document has been explained to me and all of my questions have been answered satisfactorily.

This Authorization expires in 90 days (unless a date or event is specified here): Date/Event: _____

_____ Signature of Patient/Representative

_____ Date/Time

*Legal Authority: _____

**If signed by person other than the patient, print name and identify relationship.*

This authorization is NOT valid unless it is signed and dated by the patient or their representative

Patient Identification - Write in or attach patient label

Name:

MRN#:

CSN#:

Age/Sex:

AUTHORIZATION FOR VERBAL DISCLOSURES

MultiCare

87-2984-4 (12/18)

WHO MAY SIGN THIS AUTHORIZATION:

1. Generally, all patients 18 years of age or older must sign for communication of their own health information unless the patient lacks capacity. Minor consent authority is outlined below.
2. All persons signing for communication of health information on behalf of the patient must state their relationship to the patient and provide proof of legal authority of their capacity to act for the patient

Release of Information under this document is limited to VERBAL discussions only. This authorization does not authorize release of written information or copies of medical records to the individuals listed. **Use the MultiCare Consent to Use or Release My Health Care Information** form.

REVOCATION OF CONSENT

You may revoke this consent in writing. You may call one of the departments listed or obtain the hospital address under Health Information Management (Medical Records) Locations on https://www.multicare.org/medical records.
The revocation will be effective upon receipt, but will not apply to information that has already been released or to services already provided according to this consent.

Inland Northwest Deaconess Hospital	509-473-7421
Inland Northwest Rockwood Clinic	509-342-3955
Inland Northwest Valley Hospital	509-473-5431
Puget Sound MultiCare Hospitals	253-403-2433

SUBSTANCE USE DISORDER PROGRAM INFORMATION

Federal law (42 CFR Part 2) forbids any unauthorized disclosure or additional release of substance use disorder program information without the written consent of the person whose information it is. Capable minors under the age of 13 must consent to disclosures in addition to the parent or legal guardian. Federal rules limit any use of this information to criminally investigate or prosecute any substance use disorder patient. If information is being released to an entity or class of participants under a general designation, upon request, a list of entities the information was disclosed to will be provided according to 42 CFR Part 2.

MENTAL HEALTH SERVICES INFORMATION

State law forbids most disclosures of mental health information without specific written consent of the person whose information it is. The parent or legal guardian of a minor child may consent unless the minor patient is 13 or older. In that case, signature of the patient is required. A general authorization to release information is NOT enough for this purpose. (RCW 70.02.230)

SEXUALLY TRANSMITTED DISEASE INFORMATION (Includes HIV/AIDS)

State law forbids most disclosures of this information without specific written consent of the person whose information it is. The parent or legal guardian of the minor child may consent unless the patient is 14 or older. In that case, the signature of the patient is required. A general authorization to release information is NOT enough for this purpose. (RCW 70.02.220)

GENETIC INFORMATION

Genetic information includes many things, ranging from the results of any genetic testing, to your family's medical history. It also includes information about any genetic disorders or conditions you have or might have, as well as any genetic services you have received, are currently receiving, or have requested to receive. Also included is genetic information about a pregnancy, fetus, or embryo (including if in-vitro fertilization, or other assisted reproductive technology is used).

CONSENT FOR MINOR

A signature of a minor patient is required to release information concerning care for: (1) birth control and pregnancy-related care, (2) sexually transmitted disease information (including HIV/AIDS) if the minor is 14 or older, (3) substance use disorder diagnosis, treatment, or referral information (for capable minors under 13, both child and guardian must consent), and (4) outpatient mental health information if the minor is 13 or older.

PROHIBITION ON REDISCLOSURE OF HEALTH INFORMATION

Federal or state law may restrict the redisclosure or further use of information related to substance use disorders, sexually transmitted diseases, genetic information and information related to mental health.