Cascadia Women's Clinic

Suzanne Slayton- Milam, MD, FACOG
Lisa Gibbons, DO, FACOOG
Mieke Lane, DO FACOOG
Jessica Kam, DO
Jennifer Guthrie, CNM
Jessica Young, ARNP

VERBAL DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name_____ Date of Birth_____

HIPAA (The Health Insurance Portability and Accountability Act) gives you the right to request that we communicate financial and or medical information to you in confidence by a particular method. In order to protect the privacy and confidentiality of your information, please complete the following. This form will tell us how you wish to be contacted and with whom we may discuss your healthcare, insurance and billing questions.

I give permission for (check all that applies):

Confidential messages (such as appointment reminders, normal test results) may be left on my voicemail.

HOME PHONE #_____

WORK PHONE #_____

CELL PHONE #_____

Text confirmation for appointments CELL PHONE #_____

I hereby authorize Cascadia Women's Clinic to release PHI to the person(s) listed below: (i.e. spouse, family members, friends, caregiver, etc.)

Name	Phone Number	Relationship to Patient
Name	Phone Number	Relationship to Patient
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I understand that I may revoke this authorization at any time by notifying Cascadia Women's Clinic in writing and the revocation will be effective on the day noted.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state regulations.

Patient or legally authorized individual signature Date

Printed name if signed on behalf of the patient Relationship