6703 W Rio Grande Ave.
Kennewick, WA 99336
Ph: 509-460-5588
Fax: 509-783-5438

HIPAA Consent Form

Patient's Full Name

Address

Patient's Date of Birth

City, State Zip Code

Patient's Telephone Number

I hereby authorize **VERBAL** use or disclosure of protected health information about me as described below. This consent does not serve as a release of medical records. Any medical records requests will need to be submitted in writing.

The following may receive disclosure of protected health information about me:

Name:_____ Relationship to Patient: _____

Name:_____ Relationship to Patient: _____

Name:_____ Relationship to Patient: _____

Name:_____ Relationship to Patient: _____

DO NOT DISCLOSE INFORMATION ABOUT ALCOHOL/SUBTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH. ☐

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

I may revoke this authorization by notifying TCO in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. This authorization remains in effect until revoked by the patient.

Signature of Individual*
(The person about whom the information relates)

Date of Individual's Signature

Date of Birth

OR, if applicable –

Signature of Guardian or Personal Representative of Patient's Estate

Date of Guardian's/Personal Representative's Signature

Description of Authority to Act for the Individual