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 following individual(s) regarding my medical care, including my medical condition, test results, appointment dates/times.

Name	Relationship	Telephone Number

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

❑ **Phone:** Phone messages may include reminder phone calls for important health services and appointment reminders. Please check the preferred number for staff to contact.

❑ **Home #:** _____

❑ **Cell #:** _____

❑ **Text Messaging**: Text messages may include reminders for important health services and appointment reminders.

❑ **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 notification when WHS test results and other information is available. You can retrieve messages by logging on to the secure portal or by using the HEALOW app.

eMail address: _____

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

Signature: _____ Date/Time: _____
(Patient or Authorized Signature/Relationship)

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