WhidbeyHealth Medical Center
101 N. Main Street, Coupeville WA, 98239
360.678.5151 360.321.5151
www.whidbeyhealth.org

CONSENT for LEAVING MESSAGES
CONSENT to LEAVE MESSAGES/SHARE INFORMATION WITH FAMILY/FRIENDS

I understand that my healthcare information at WhidbeyHealth Medical Center's Medical Ambulatory Care and Oncology Clinic is protected and I have received a copy of a Notice of Privacy Practices.

I further understand that in order for the Medical Ambulatory Care Department to leave **detailed messages containing specific medical information** on my voice mail or answering machine, I need to give permission to Medical Ambulatory Care of WhidbeyHealth Medical Center to do so.

Consent for Leaving Messages

I consent to information regarding my or my child's (under the age of 18) lab test results or detailed appointment reminders/instructions be left on my voice mail or answering machine. I understand that "sensitive" information as noted below will be excluded. ☐ **YES** ☐ **NO**

Consent for Shared Information with Family & Friends

The name(s) listed below are family members or friends to whom I grant permission for my healthcare providers and their representatives at WhidbeyHealth Medical Center's Ambulatory Care and Oncology Clinic to verbally discuss my care using their best judgment, and grant them permission to disclose health information that is relevant to my care or relevant for payment. ☐ **YES** ☐ **NO**

Under the HIPPA Privacy Law we are permitted and we may make a professional judgment that certain disclosures are in your best interests even without this signature.

I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information form.

I understand that some information, as listed below, is considered "sensitive." I understand that I must check specific boxes in order for my provider or his/her designee to discuss any "sensitive" information with the listed family or friend.

- ☐ Mental Health/Psychiatric disorders (including depression)
- ☐ Chemical Dependency (drug and/or alcohol abuse/ treatment)
- ☐ Pregnancy information
- ☐ HIV/AIDS Virus
- ☐ Sexually Transmitted Diseases

NAME	RELATIONSHIP & Phone Number
1_____	_____
2_____	_____
3_____	_____

_____
Patient/Parent Signature Date

It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time.
This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that to revoke this consent must provide written notice to the staff at WhidbeyHealth Medical Center.