OPTIMAL HEALTH MEDICAL CENTER

750 George Washington Way, Suite 5
Richland, WA 99354

CONSENT TO INFORM—YOUR RIGHT TO PRIVACY

Patient's Name ____

We respect your right to privacy regarding medical information. Without additional written consent, may we share information with your spouse?

☐ No

☐ Yes. If yes, their name: ___________________________

We understand you may have concerned relatives. Please list the names of adults, children, other family members and/or contact persons with whom we may share information, without additional written consent, and their relationship to the patient:

☐ Check if N/A (not applicable)

Name: ___________________________ Relationship: ______________________

Name: ___________________________ Relationship: ______________________

What information may we share?

☐ All

☐ Scheduling Info Only

☐ Other. Please specify ____

*Note: If there are any changes on this form, it is the patient's responsibility to let us know at each occurrence.

____

Signature of patient or authorized representative Date

Relationship or status if signed by anyone other than patient: _____________________________

THIS AUTHORIZATION WILL EXPIRE YEARLY, UNLESS OTHERWISE REVOKED