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.

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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