Obtaining Verbal/Written Authorization (Permission) to Use or Disclose Protected Health Information

Mason Health may wish to use or disclose your protected health information to individuals involved in your care for notification purposes. As stipulated by Title 45, Section 164.10, we are permitted to make such uses or disclosures with your verbal or written permission.

*****This authorization excludes medical information for patients ages 13-17, which are specially protected under state laws. This includes reproductive, STD, mental health, and substance abuse information.**

Mason Health is authorized to (check all that apply):

- ☐ Contact the following person(s) regarding my treatment or proposed treatment (please specify name and relationship):

  Name: ______________________________ **Relationship:** ____________________

  Name: ______________________________ **Relationship:** ____________________

  Name: ______________________________ **Relationship:** ____________________

- ☐ Include information about my mental health. *****EXCLUDES AGES 13-17**
- ☐ Notify my transportation service regarding my delivery or pick-up prior to or upon completion of my treatment.
- ☐ Other (please specify): ______________________________
- ☐ I **DO NOT** authorize Mason Health to release any medical information to anyone other than myself.

How may we contact you regarding your appointments, proposed treatments, billing questions/ problems, surgery scheduling, radiology/lab/outpatient service appointments and other situations regarding your protected health information?

Check all that apply:

- ☐ Phone
- ☐ Leave a message with authorized members listed above.
- ☐ Leave a message on my answering machine, voice mail, or cell phone.
- ☐ Other (Please specify):______________________________

I understand that I may refuse to sign this authorization. I understand my refusal will not affect my ability to obtain treatment at any Mason Health campus.

I may revoke this authorization at any time by submitting Consent to Revoke Prior Authorization form MGH 1778 to Mason Health. The revocation will be effective at Mason Health upon receipt of my written notice, except that it will not have any effect on any action already taken by Mason Health on this authorization.

I understand that once Mason Health has disclosed my health information to the recipient, Mason Health cannot guarantee that the recipient will not re-disclose my health information to a third party.

This authorization will remain valid as long as I am a patient at Mason Health. By my signature below, I hereby, knowingly and voluntarily, authorize Mason Health to verbally disclose my health information or fulfill specific instructions in the manner described above and revoke all previously signed Clinic Verbal Authorization forms.

Patient/Representative Signature: ______________________________ Date/Time: ____________________

Printed Name of Personal Representative: ______________________________ Relationship: ____________________

Patient Label	Clinic Verbal Authorization Mason Health P.O. Box 1668, 901 Mountain View Drive, Shelton, WA 98584 MGH 495 REV 2/2024 *SCAN TO HIPAA PRIVACY/DISCLOSURE DOCUMENT*