1616 Cornwall Ave
Bellingham, WA 98225
Phone: (360) 676-6177
Fax:(360) 671-3574

# Authorized Communication Form

Please use this form to tell us if we can leave detailed phone messages, and/or, who can be involved in your care at Unity Care NW (UCNW), including who we can speak to about your healthcare.

**Patient Legal Name**: _____ **Date of Birth:** _____

Patient Preferred Name: _____

**I authorize Unity Care NW to leave detailed messages, which may include protected health information, on the phone numbers listed below:**

**Authorized Phone Number(s)**: _____

_____

_____

**Individual(s) I authorize to be involved in my care:**
*There is room for additional authorized representatives on the back side of this form.*

**Name:** _____ **Date of Birth:** _____

**Phone Number:** _____ **Relationship to Patient:** _____

**I authorize this individual to be involved in the following:**

- ☐ Updating my demographic information (except name and date of birth)
- ☐ Discussing and sharing of my healthcare information with appropriate UCNW staff.
  Additionally, I choose to share the following protected healthcare information:
  *(If left unchecked, or a minor's signature is not provided (ages 13-17), this information will not be shared.)*
  - ☐ Alcohol, Drug, or Substance Use
  - ☐ Sexually Transmitted Diseases
  - ☐ HIV/AIDS
  - ☐ Mental Health
  - ☐ Reproductive Care
  - ☐ Genetic Records

**Minor Patient Signature** **Print Name**

*A minor patient's signature is required to disclose information related to reproductive care (at any age), sexually transmitted diseases (14 or older), HIV/AIDS (14 or older), alcohol, drug, or substance use (13 or older), and mental health (13 or older).*

**This authorization ends** when I revoke my authorization in writing and mail it to Unity Care NW's Health Information Management Department at the address at the top of this form or by dropping it off at any UCNW front desk. Any such revocation will not apply to activity previously undertaken based on this authorization.

**Patient or Legally Authorized Representative Signature** **Date**

**If Signing for Patient - Print Name** **If Signing for Patient – Relationship to Patient**

**Individual(s) I authorize to be involved in my care:**

**Name:** _____ **Date of Birth:** _____

**Phone Number:** _____ **Relationship to Patient:** _____

**I authorize this individual to be involved in the following:**

- ☐ Updating my demographic information (except name and date of birth)
- ☐ Discussing and sharing of my healthcare information with appropriate UCNW staff.
  Additionally, I choose to share the following protected healthcare information:
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  - ☐ HIV/AIDS
  - ☐ Mental Health
  - ☐ Reproductive Care
  - ☐ Genetic Records

_____

**Minor Patient Signature** **Print Name**

*A minor patient's signature is required to disclose information related to reproductive care (at any age), sexually transmitted diseases (14 or older), HIV/AIDS (14 or older), alcohol, drug, or substance use (13 or older), and mental health (13 or older).*

**Individual(s) I authorize to be involved in my care:**

**Name:** _____ **Date of Birth:** _____

**Phone Number:** _____ **Relationship to Patient:** _____

**I authorize this individual to be involved in the following:**

- ☐ Updating my demographic information (except name and date of birth)
- ☐ Discussing and sharing of my healthcare information with appropriate UCNW staff.
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_____

**Minor Patient Signature** **Print Name**

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