HIPAA OPT-OUT FORM

Kirkpatrick Family Care ■ 1706 Washington Way ■ Longview, WA 98632 ■ (360) 423-9580

1. DO YOU WANT YOUR FAMILY AND FRIENDS TO HAVE ACCESS TO YOUR HEALTH INFORMATION:

The HIPAA Privacy Rule requires Kirkpatrick Family Care to provide each patient with the opportunity to agree, limit or object to any health information that may be provided to the patient's family or friends. To take advantage of this opportunity, please complete, sign and date the following sections. If you have any questions on how to complete this form, please contact Kirkpatrick Family Care's Privacy Official.

2. YOUR PERSONAL INFORMATION:

Name: _____ Birthdate: _____

SSN: _____ Phone #: _____

Address: _____

3. OPT-OUT PROCEDURE:

If you would like to agree, limit or object to your health information being shared with your family and friends, please check the corresponding box:

☐ Agree ☐ Limit ☐ Object

Please describe your wishes in detail. If necessary, include individuals' names and your relationship to them.

_____

_____

_____

_____

4. AUTHORIZATION:

I authorize Kirkpatrick Family Care to follow the above-stated Opt-out Procedure:

Signature: _____ Date: _____

If a legal representative fills out this form, he/she must complete the following:

Representative's Name: _____ Relationship: _____

KIRKPATRICK
FAMILY CARE