



Patient Confidential Communication Consent

Your privacy is our most important goal. Many of our patients allow family members, caregivers, or others to request medical or billing information on their behalf. Federal law requires that your information may not be shared with anyone, unless law allows it or permission has been given. By signing this form you agree to share your Protected Health Information (PHI) with the individuals named below.

Please note: Anyone listed below as having permission to have access to your Protected Health Information (whether on paper, electronic, or verbal) will have access that may include specially protected records (i.e. HIV results) ORS333-022-0210.

I authorize the following person(s) to discuss, receive written documents and/or have access to my Athena Patient Portal account with all my personal health information, which includes billing/financial and insurance information, appointments, and all health information and treatments.

- 1) _____ Relationship _____ Phone _____
- 2) _____ Relationship _____ Phone _____
- 3) _____ Relationship _____ Phone _____
- 4) _____ Relationship _____ Phone _____

- I understand I must sign a separate medical records release authorization to release copies of my medical record to another individual.
- I understand I have the right to revoke my permission at any time except where Colorectal Health NW has already made disclosures in reliance upon prior requests. I understand this permission remains in effect until the time I revoke it in writing.

Patient Name - Please print

Date of Birth

Signature of Patient or Guardian

Date

Name and Relationship of Guardian