CASCADE HEMOPHILIA CONSORTIUM

Authorization for Communication of Protected Health Information to Family Members and Friends

1. **By signing this form, I authorize Cascade HC to disclose to the following individuals protected health information directly relevant to their involvement in my care or payment related to my care:**

Name:	Relationship:	Home Phone No: Mobile Phone No:
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2. **I AUTHORIZE Cascade HC to leave detailed phone messages at the above-listed phone numbers about my prescription, shipment, and/or insurance information either, at Cascade HC's discretion, by speaking with the person answering to the name associated with that number, or by leaving a voicemail at the phone number.**

3. **I UNDERSTAND that the information disclosed by Cascade HC to the individuals listed above may no longer be protected from further disclosures.**

4. **I UNDERSTAND that I may refuse to sign this Authorization.**

5. **I UNDERSTAND that I may revoke this authorization at any time by clearly communicating my revocation to Cascade HC. Submitting a new form will revoke the existing form.**

Signature of Client or Parent (if minor): _____

Signature of Guardian/Personal Representative (if applicable):

_____

Client Name (printed): _____

Client Date of Birth: _____

Date: _____