Coos Health & Wellness

Together, Inspiring Healthier Communities

Objection to Uses and Disclosure of Protected Health Information for Certain Purposes

Client' Name: _____ _____ _____ Birth Date:_____
Last First Middle

Address: _____ _____
Street Zip

Phone #: _____ _____ _____
Home Cell Work

I understand that Coos Health & Wellness has a Notice of Privacy Practices (the "Notice"). I hereby acknowledge that by my review of the Notice, Coos Health & Wellness has informed me that my health information may be used or disclosed for one or more of the purposes described below. I further understand that Coos Health & Wellness will not disclose any of My Highly Confidential Health Information other than those permitted by law for treatment payment and health operations. I acknowledge that the Coos Health & Wellness has provided me with the opportunity to prohibit these uses or disclosures.

1. For Involvement of Others in My Care. Disclosure of my Protected Health Information to a family member, other relative, close personal friend, or any other person identified by me, that is directly relevant to that person's involvement with my care or payment for my care.
2. For Notification of My Location, General Condition or Death. Disclosure of my Protected Health Information to notify (or assist in the notification of) my family member (or personal representative or other person responsible for my care) of my location, general condition or death.
3. For Disaster Relief Efforts. Disclosure of my Protected Health Information to a public or private entity authorized to assist in disaster relief efforts in order to coordinate efforts to notify (or assisting in the notification of) my family member (or personal representative or other person responsible for my care) of my location, general condition or death.

By my signature below, I hereby prohibit the use and disclosure of my health information for the following listed purposes:

- ☐ Involvement of Others in My Care
- ☐ Notification of My Caregiver
- ☐ Disaster Relief Efforts

By my signature below, I hereby agree to:

☐ the use and disclosure of my health information for all of the three purposes described above, subject to the following restriction(s): _____

_____ _____
Signature of Client (or Personal Representative) Date of Signature

_____ _____
Printed Name of Personal Representative Relationship to Client