Patient Information for Inclusion in the UW Medicine Patient Directory

Please Read this Statement Carefully

I understand that I have a choice as to whether or not to be included in the UW Medicine patient directory. My name and location will be included in the patient directory unless I would prefer not to receive phone calls or visitors. My decision is indicated by marking a box and signing this form.

☐ **YES, please include me in the Patient Directory.** The hospital has informed me that my name and location will be included in its hospital directory. This information will be made available to people who ask for me by name such as my relatives, friends and fellow employees

- Harborview Medical Center
- Northwest Hospital and Medical Center
- University of Washington Medical Center / Seattle Cancer Care Alliance
- Valley Medical Center

If I have provided my religious affiliation to UW Medicine in the past or if I provide my religious affiliation to UW Medicine now, I authorize its disclosure to clergy of my religious affiliation. Disclosure of my religious affiliation may result in a visit from a clergy member of my affiliation while I am being treated at UW Medicine.

If you have provided your religious affiliation to UW Medicine in the past and do not want a visit from a clergy member of your affiliation, please inform the registration staff.

☐ **NO, please do not include me in the Patient Directory.** I do not want my name or location included in the UW Medicine Patient Directory. **If this is my choice, I understand UW Medicine staff will <u>not</u> be able to confirm I am a patient or share my location with any family or friends. I also understand that by choosing not to be in the directory, UW Medicine will be unable to deliver items *(for example, flowers and gifts)* addressed to me.**

For Staff Use Only

☐ **ADMIN OPT-OUT:** Please provide reason for Administrative Opt-Out

☐ Crime Victim ☐ Employee ☐ Incarcerated Patient

☐ Involuntary Commitment ☐ Unable to Interview Patient ☐ Media Interest

Name of person requesting opt out *(if other than patient)*:_____

By signing below, it shows that you have read this document. If there is any part of this form that is unclear, be sure to ask questions about it.

Date	Signature *(Patient or Person Authorized to Give Authorization)*

IF SIGNED BY PERSON OTHER THAN PATIENT, CHECK RELATIONSHIP TO PATIENT:

☐ 1. Guardian ☐ 2. Durable Power of Attorney for Health Care ☐ 3. Spouse/registered domestic partner

☐ 4. Adult Child(ren) ☐ 5. Parent(s) ☐ 6. Adult Brother(s)/Sister(s)

FOR MINOR PATIENTS:

☐ 1. Guardian/legal custodian ☐ 2. Court-authorized person for child in out-of-home placement ☐ 3. Parent(s)

☐ 4. Holder of signed authorization from parent(s) ☐ 5. Adult representing self to be a relative responsible for the minor's health

PT.NO

NAME

DOB

Place EPIC Label Within Box

UW Medicine
Harborview Medical Center – Northwest Hospital & Medical Center
Valley Medical Center – UW Medical Center
University of Washington Physicians Seattle, Washington

PT INFORMATION FOR UW MEDICINE PATIENT DIRECTORY

U1868

UH1868 REV JAN18

WHITE – MEDICAL RECORD
CANARY – PATIENT

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