UW MEDICINE COMPASS EXPANDED AUTHORIZATION FORM

COMPASS

WELCOME TO THE UW MEDICINE COMPASS PROGRAM!

Please return this form by using the envelope provided. Thank you!

In order for UW Medicine advancement staff to better assist with non-medical coordination whenever you are in our care, we ask that you fill out this authorization form. The authorization you provide is strictly limited to your participation in the UW Medicine Compass Program.

By completing this form, you are allowing UW Medicine to provide UW Medicine Advancement staff with information related to care provided at UW Medicine hospitals. This information, used to help facilitate non-medical requests related to your participation in the UW Medicine Compass Program, includes:

- Reason for visit (including admission diagnosis and/or admission procedure when applicable);
- Number of days you're expected to be in the hospital;
- Room number; and
- Discharge status (such as home, other institution, skilled nursing facility).

As part of our efforts, we may visit when you are in our facility to see if you have any additional non-medical needs. We will always check with clinical staff before we visit to ensure you wish to be visited and the timing is appropriate.

Please know this authorization is voluntary. You can still access all of your UW Medicine Compass benefits today, and if further authorization is ever needed for additional services, we will reach out again. If you have any questions, please contact us at compass@uw.edu or 206.543.0190.

This authorization expires on the date when your participation in the UW Medicine Compass Program is no longer active.

Patient Rights: I understand I do not have to sign this authorization in order to obtain healthcare benefits (treatment, payment, or enrollment). I may revoke this authorization at any time, except to the extent already relied upon, by sending a request in writing to the UW Medicine Compliance Office, Box 358049, Seattle, WA 98195. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under privacy laws.

(Please see reverse side)

PT. NO

NAME

DOB

UW MEDICINE
Harborview Medical Center — Northwest Hospital & Medical Center
Valley Medical Center— UW Medical Center
University of Washington Physicians, Seattle Washington

COMPASS AUTHORIZATION
U3418
UH3418 REV JAN 17 | White - Medical Record

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I understand I have the following rights to:

- Inspect or to receive a copy of my protected health information;
- Receive a copy of this signed form; and
- Refuse to sign this form for authorization to disclose or release my protected health information.

I also understand UW Medicine will not base treatment or payment decisions on receipt of this signed authorization, except in these cases: (1) UW Medicine may condition research-related treatment on my signing or my providing an authorization for the use or disclosure of my information for such research; or (2) UW Medicine may condition the provision of healthcare that is just for the purpose of creating protected health information for disclosure to a third party on my signing or my providing an authorization for the disclosure of the health information to such third party. An example of this is when a non-UW employer contracts with UW Medicine to conduct TB testing for purposes of employee health screening.

This authorization form can be sent to us by mail or by fax. If the patient chooses to accept the risks associated with unencrypted email — that email communications could potentially be read by a third party — this form may be sent by email.

By signing this page, I acknowledge that I have read and agree to the terms on both sides of this form.

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

If Signed by Person Other Than Patient, Provide Reason, Relationship to Patient, Description of Authority

Confirm Your Information (Please complete.)

Your Name Birth Date

Address

City State ZIP

Email Daytime Phone

UW Medicine

Please return this form by using the envelope provided. Thank you!

UW Medicine Compass
Box 358045
Seattle, WA 98195-8045

Phone: 206.543.0190
Fax: 206.685.9889
compass@uw.edu

PT. NO

NAME

DOB

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

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