HEALTH HISTORY INTERVIEW - CONSENT AND AUTHORIZATION TEMPLATE
For informational purposes only. Not legal advice. Have your attorney, Privacy Officer, or IRB review before use.
Washington State: All-party consent required for recording.

FORM A: INTERVIEW CONSENT + RECORDING CONSENT (Use for everyone)

Title of Project / Interview: _____

Interviewer Name / Organization: _____
Date: _____ Location: _____

1. Purpose: I understand I am being asked to participate in an interview about my health history for [describe: e.g., school project, podcast, research study, oral history].

2. What will happen: I will be asked questions about my health history. The interview will take approximately ____ minutes and may be audio / video recorded.

3. Voluntary: My participation is voluntary. I can skip any question, stop at any time, and request that my information not be used up to [date / point].

4. Confidentiality and Use:
   - [ ] My name may be used
   - [ ] Use initials / pseudonym only
   - My information will be used for: _____
   - Stored where / how long: _____
   - Who will have access: _____

5. No medical advice: This interview is not medical care and does not create a provider-patient relationship.

6. Washington Recording Consent: I understand Washington law requires consent of all parties to record a private conversation. I consent to being audio / video recorded for this project.

7. Release: I give permission for the interviewer to use my de-identified or identified responses as described above.

Participant Printed Name: _____
Participant Signature: _____ Date: _____
Interviewer Signature: _____ Date: _____

I will provide you a copy of this signed form.

FORM B: HIPAA AUTHORIZATION (Only if you or the disclosing party are a HIPAA covered entity)
This must be plain language and separate from Form A if you are a covered entity.

HIPAA Authorization to Use and Disclose Protected Health Information

1. Description of information: I authorize the use/disclosure of: [Be specific, e.g., "health history information I provide during interview on

[date] regarding diagnosis of ___" or "medical records from ___ clinic from ___ to ___"]

2. Person authorized to make disclosure: Name: _____

3. Person / organization authorized to receive: Name: _____

4. Purpose of disclosure: [e.g., "at the request of the individual for participation in health history interview" or "for research study titled ___"]

5. Expiration: This authorization expires on: [date, event, or "no expiration" with explanation] _____

6. Required Statements:
- I understand I may revoke this authorization in writing at any time, except to the extent action has already been taken. Revocation address: _____
- I understand that signing is voluntary and treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing, except as allowed by law.
- I understand information disclosed under this authorization could be re-disclosed by the recipient and may no longer be protected by federal privacy law.
- I will be given a copy of this signed authorization.

Signature of Individual: _____ Date: _____
Printed Name: _____ DOB: _____
If signed by personal representative, relationship / authority: _____

Retain for at least 6 years.