

Authorization to Use or Disclose Protected Health Information

Patient name: _____ Date of birth: _____

Previous name: _____

I. My Authorization

I request and authorize:

Address: _____

Phone: _____

Fax: _____

You may disclose the following health care information (check all that apply):

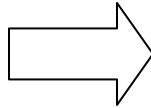
- All health care information in my medical record
- Health care information in my medical record relating to the following treatment or condition:

- Health care information in my medical record for the date(s): _____
- Other (e.g., X-rays, bills), specify date(s): _____

DO NOT INCLUDE the following health care information regarding testing, diagnosis, and treatment for (check all that apply):

- HIV (AIDS virus)
- Sexually transmitted diseases
- Psychiatric disorders/mental health
- Drug and/or alcohol use

You may disclose this health care information to:



Whidbey Island Internal Medicine PO
Box 746, Coupeville, WA 98239 Phone: 360-678-
4440 Fax: 360-678-9244

REASON FOR THIS AUTHORIZATION: (check all that apply)

- Permanent transfer of medical care
- other (specify) _____

This authorization ends:

- on (date): _____ when the following event occurs: _____
- in 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes other than payment)

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form:

- To take part in a research study **or**
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by **Whidbey Island Internal Medicine** based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from **Whidbey Island Internal Medicine**, **or**
- Write a letter to **Whidbey Island Internal Medicine**.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship (parent, legal guardian, personal representative)