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)