north seattle PEDIATRICS

Authorization to Use or Disclose Protected Health Information

Patient Name:_____Previous Name:_____Date of Birth:_____

I. My Authorization

North Seattle Pediatrics may use or 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 date(s):_____
- ☐ Other (e.g., x-rays, bills) – specify date(s):_____

Uses and Disclosures Requiring Specific Authorization

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

- ☐ HIV/AIDS
- ☐ Sexually Transmitted Diseases
- ☐ Mental Health or Illness
- ☐ Drug and/or Alcohol Abuse
- ☐ Reproductive Care (minors only)

Minors - a minor patient's signature is required in order to disclose information related to reproductive care, sexually transmitted diseases (if age 14 and older), HIV/AIDS (if age 14 and older), drug and/or alcohol abuse (if age 13 and older).

You may disclose this health care information to:

*Name (or title) and organization or class of persons:*_____

*Address:*_____*City:*_____*State:*_____ *Zip:*_____

Reason(s) for this authorization to use of disclose my health care information (check all that apply):

- ☐ at my request
- ☐ 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 that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits). However, I do have to sign an authorization form:

- to receive research-related treatment in connection with research studies **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 at any time. If I do, it will not affect any actions taken by North Seattle Pediatrics in reliance on this authorization before it receives my written revocation. 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 revocation form –a form is available from North Seattle Pediatrics **or**
- write a letter to North Seattle Pediatrics.

III. Protection after Disclosure. I understand that once my health care information is disclosed, the person or organization that receives it my re-disclose it and that 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 to patient (parent, legal guardian, personal representative)

_____

Minor patient's signature, if applicable Date Time