Authorization to Use or Disclose Protected Health Information

Patient Name:___________________________________Previous Name:_________________Date of Birth:_____________

Parent Name:____Contact Phone Number________________________________

I. My Authorization

- ☐ 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):____

TO BE SENT ***FROM***:	TO BE SENT ***TO***:
Name:____	Name:____
Address:____	Address:____
Phone:_____________________Fax:____________________	Phone:____________________Fax:_____________________

Uses and Disclosures Requiring Specific Authorization

Unless marked, we may disclose health care information regarding testing, diagnosis, and treatment for all following conditions:

☐ 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).

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 the revocation form available from North Seattle Pediatrics
- 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 may re-disclose it and that privacy laws may no longer protect it.

Patient or legally authorized individual signature____Date_________________ Time_____________

Printed name____Relationship to patient____

Minor patient's signature, if applicable____Date__________________Time___________