

# Authorization to Use or Disclose My Health Care Information

TO: \_\_\_\_\_ Address: \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_ Tel # \_\_\_\_\_

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Social Security # \_\_\_\_\_ Previous Name \_\_\_\_\_

## I. My Authorization

**You 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 the date(s): \_\_\_\_\_
- Other (e.g., X rays, bills), specify date(s): \_\_\_\_\_

**You may use or disclose 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:**

Family Medicine of Port Angeles  
303 W 8<sup>th</sup> St  
Port Angeles WA 98362  
360-452-7891

**Reason(s) for this authorization (check all that apply):**

- at my request
- other (specify) \_\_\_\_\_

- This authorization ends:** *(This document does not permit disclosure of health information created more than 90 days after the date it is signed.)*

- when the following event occurs: \_\_\_\_\_  
(no longer than 90 days from date signed)

## 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 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 Family Medicine of Port Angeles 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 Family Medicine of Port Angeles. Or
- Write a letter to Family Medicine of Port Angeles.

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)

**Authorization to Use or Disclose Health Care Information**  
**Family Medicine of Port Angeles**  
**303 W 8<sup>th</sup> St Port Angeles WA 98362 360-452-7891**

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Previous name: \_\_\_\_\_

**I. My Authorization**

**You 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 the date(s): \_\_\_\_\_

Other (e.g., X rays, bills), specify date(s): \_\_\_\_\_

**You may use or disclose 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:**

Name (or title) and organization: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Reason(s) for this authorization (check all that apply):**

- at my request
- other (specify) \_\_\_\_\_
- check only if [practice/ facility] requests the authorization for marketing purposes
- check only if [practice/facility] will be paid or get something of value for providing health information for marketing purposes

**This authorization ends:** Date \_\_\_\_\_ Other(specify) \_\_\_\_\_

when the following event occurs: \_\_\_\_\_

**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 [name of practice or health care facility] 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 the [practice/health care facility]. Or
- Write a letter to the [practice/health care facility].

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)