

Authorization to Release Protected Health Information

Please fill out form COMPLETELY to be sure that your MEDICAL RECORDS are not delayed.

Patient name: _____ Date of birth: _____

Previous name(s): _____

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 NOT disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

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

Who will RECEIVE the health care information?

Name/Organization: _____

Address: _____

City: _____

State: _____ Zip: _____

Ph: _____ Fax: _____

Who will SEND the health care information?

Name/Organization: **Women's & Family Health Specialists**

Address: **1412 SW 43rd St, Suite 200**

City: **Renton**

State: **WA** Zip: **98057**

Ph: **425-271-4910** Fax: **425-264-1041**

Reason(s) for this authorization (check all that apply): (Charges for copies of records may apply, see back for information)

- Continuing Care Doctor
- Transfer of Care
- Personal/Own Use
- Insurance
- 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 Women's & Family Health Specialists 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 Medical Records Department Or
- Write a letter to Women's & Family Health Specialists.

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