

YELM FAMILY MEDICINE

Authorization to Use or Disclose Health Care Information

Patient Name: _____ DOB: _____

Previous Name: _____ SS# _____

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): _____

EXCLUDE the following information from the records released (Please initial):

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

I request and authorize:

Yelm Family Medicine
201 Tahoma Blvd. S.E. Ste. 102
Yelm, WA 98597
Ph: 360-458-7761 Fax 360-458-6612

To release my records to:

Clinic/Provider Name _____
Address: _____
City _____ State _____ ZIP _____
Ph: _____ Fax: _____

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

- At my request
- Attorney request
- Physician request
- Other (specify) _____

This auth. ends: *(This document does not permit disclosure of health information created more than 90 days after date signed)*

- In 90 days from the date signed
- 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 affect any actions already taken by Yelm Family 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:

1. Fill out a revocation form (or)
2. Write a letter to Yelm Family 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

Printed Name if signed on behalf of the patient

Relationship (Parent, legal guardian, personal rep.)