Authorization to Use or Disclose Protected Health Information

Patient Name: _____ Date of Birth: _____

Previous Names: _____

I. My authorization

Yelm Family Medicine, PLLC may use or disclose the following health care information (Check all that apply):

- ☐ All health care information in my medical record
- ☐ Heath care information in my medical records 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): _____

Uses and Disclosures Requiring specific authorization

Please check the following if you wish to have them excluded from your records disclose:

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

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

I request and authorize:

Clinic Name

_____

Address:

_____

_____

Phone: _____ Fax: _____

To release my records to:

Clinic Name

_____

Address:

_____

_____

Phone: _____ Fax: _____

Reason(s) for this authorization to use or disclose my health care information (Check all the apply):

- ☐ at my request
- ☐ for marketing purposes
- ☐ check here if **Yelm Family Medicine, PLLC** will be paid for providing health care information for marketing purposes by the third party whose product or service is described in the marketing
- ☐ other (specify) _____
- ☐ physician request

This authorization ends 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) unless otherwise noted.

_____

II. My Rights

1. I understand that I do not have to sign this authorization in order to receive 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 it to create health care information for a third party.
2. I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by **Yelm Family Medicine, PLLC** 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 a revocation form—a form is available from **Yelm Family Medicine, PLLC** or
   - Write a letter to **Yelm Family Medicine, PLLC**.

III. Protection after Disclose

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 (if signed on behalf of the patient) Relationship (Parent, legal guardian, etc.)

_____

Minor patient's signature, if applicable Date Time