FOR INTERNAL USE ONLY
INITIALS_____
DATE_____

Authorization to Use or Disclose Protected Health Information

****PLEASE ATTACH THIS PAGE WHEN SENDING OR FAXING RECORDS BACK**

*** We are a Partners affiliated Epic Care Everywhere Practice ***

Pt name: _____DOB: _____

Previous Name:_____

My Authorization

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

□ Medical records from the **Last 3 years**

□ 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 (Radiology reports, immunizations, labs)—specify date(s): _____

Uses and Disclosures Requiring Specific Authorization
Please check the following if you wish to have them <u>EXCLUDED</u> from your records disclosure:

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

I request and authorize:	**To release my records to:**
Yelm Family Medicine, PLLC	Clinic Name:_____
201 Tahoma Blvd. S.E. Ste 102	Address:_____
Yelm, WA 98597	City,State,Zip_____
PH: 360-458-7761 FAX: 360-706-1183	Ph:_____Fax:_____
	Email:_____

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Reason(s) for this authorization to use or disclose my health care information (check all that 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 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.

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 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.

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), and mental health or illness (if age 13 and older).

_____

Patient or legally authorized individual signature Date Time

_____

Printed name (if signed on behalf of the patient) Relationship (parent, legal guardian, personal representative)

_____

Minor patient's signature, if patient is over the age of 13 (**signature required**) Date Time

(If applicable please initial)

I understand there may be a fee up to $50 if I am requesting my records be sent directly to me._____
(Initials)