

Authorization to Use or Disclose Protected Health Information

Patient Name: _____ Previous Name: _____ Date of Birth: _____

I. My Authorization

Angela Heithaus MD 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 date(s):
Other (e.g., medication history, bills) - specify date(s):

Uses and Disclosures Requiring Specific Authorization

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

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

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).

You may disclose this health care information to:

Name (or title) and organization or class of persons: FAX #
Address: City: State: Zip:

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

- at my request
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 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.

I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by North Seattle Pediatrics 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 revocation form - a form is available from North Seattle Pediatrics or
write a letter to North Seattle Pediatrics.

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.

Patient or legally authorized individual signature Date Time

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

Minor patient's signature, if applicable Date Time