

# SEATTLE HEALING ARTS

## Authorization to Use or Disclose My Health Care Information

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Previous name: \_\_\_\_\_  
Westwinds family Medicine or

### I. My Authorization for Dr. Jane M Pemberton to disclose health care information.

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

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

You may disclose this health care information to:

Name (or title) and organization: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone\*\* \_\_\_\_\_ FAX\*\* \_\_\_\_\_ (\*\* required information)

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

- at my request
- other (specify) \_\_\_\_\_ Transfer of care
- This authorization ends: (This document does not permit disclosure of health information created more than 90 days after the date it is signed.)
- in 90 days from the date signed
- on (date): \_\_\_\_\_
- when the following event occurs: \_\_\_\_\_  
(no longer than 90 days from date signed)

### 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 [name of practice or health care facility] 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 [practice/health care facility]. Or
  - Write a letter to the [practice/health care facility].

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 \_\_\_\_\_ Time \_\_\_\_\_

\_\_\_\_\_  
Printed name if signed on behalf of the patient

\_\_\_\_\_  
Relationship  
(parent, legal guardian, personal representative)

Last Update: \_\_\_/\_\_\_/\_\_\_

FAX to 206 834-6246