Authorization to Use or Disclose Protected Health Information

Medical Records Release *to Bellingham Arthritis and Rheumatology Center*

Patient name: _____ Date of birth: _____

Previous name: _____

I authorize: Bellingham Arthritis and Rheumatology Center
470 C Birchwood Avenue, Bellingham, WA. 98225

To disclose this health care information to:

_____
_____
_____
_____

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

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

☐ at my request ☐ other (specify):_____

This authorization ends:

- ☐ on a specific 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)

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 addressed to the office named above. If I did, it would not affect any actions already taken by *Bellingham Arthritis and Rheumatology Center* based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. 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)