DOC TYPE

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VANCOUVER CLINIC
Authorization for Release of Protected Health Information
(Release of Records to a Third Party)
45 CFR 164.508

Medical Record Number (internal use only): _____

*Patient Name (**please print clearly**): _____ *Date of Birth: _____

*Address: _____

I hereby authorize <u>Vancouver Clinic</u> to use or disclose my protected health information as indicated below to (all fields are required):

*Name: _____

*Address: _____

*City: _____*State: _____*Zip Code: _____

*Phone Number: _____ *Fax Number: _____

You may use/disclose the following information:

_____ All health care information in my record (including immunizations, lab, pathology, and radiology reports)

_____ Immunization records only

_____ Lab/Pathology Results only (date(s) or type(s):_____

_____ Radiology images only (date(s) or type(s): _____

_____ Billing information – date(s): _____

_____ Specific Information Only (list out): _____

_____

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment***. I give my specific authorization for these records to be released <u>unless</u> I have initialed below:***

***If you wish to EXCLUDE** the following information from the records released, **please initial the lines** below:
_____ HIV-related illness, AIDS, AIDS related illness _____ Sexually transmitted diseases
_____ Psychiatric disorders / Mental Health treatment _____ Drug and/or alcohol use

***Purpose**: _____ Changing physicians/Transfer of care Other (be specific): _____

I understand this authorization is valid for a **<u>one time</u>** release, unless otherwise specified below:
_____ Authorization valid until such time or event: _____
_____ Authorization valid until revoked in writing

I understand that I do not have to sign this authorization to get healthcare benefits (treatment, payment, enrollment or eligibility).
I understand that I may revoke this authorization at any time by filling out a revocation form available at Vancouver Clinic. If you revoke this authorization, Vancouver Clinic cannot undo disclosures already released under this authorization.
I understand Information disclosed under this authorization might be re-disclosed by the recipient, and may no longer be protected by federal or state law.
I understand that I may ask for a copy of this authorization.

I understand there may be a <u>fee</u> associated with my request. RCW 70.02.030, 45 CFR 164.524

_____ _____
*Patient or legally authorized representative signature *Date

_____ _____
Relationship to Patient if signed on behalf of patient Printed name if signed on behalf of patient

<u>Release of information</u> (13898 NE 28th St., Suite B109, Vancouver, WA 98682) PHONE: 360 397-3638 | FAX: 360 604-1714
EMAIL: tvcroi@tvc.org | Radiology Fax: 360 604-1778