

DOC TYPE



10089

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 Vancouver Clinic 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/discard 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 unless 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 **one time** 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 fee 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