DOC TYPE

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The Vancouver Clinic

Authorization for Release of Protected Health Information
45 CFR 164.508 - Release of Records to a Third Party

Medical Record Number (MRN): ________________________

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

Address: ____

I hereby authorize The Vancouver Clinic to use or disclose my protected health information as indicated below to:

*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: ____
____

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: ____________________________________

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 The Vancouver Clinic. If you revoke this authorization, The 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 Printed name if signed on behalf of patient