VANCOUVER CLINIC
Authorization for Release of Protected Health Information 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</u> <u>Clinic</u> to use or disclose protected health information about the Patient as indicated below to:

Name: ____

Postal Address to receive information via hard copy: ____

City: ____State: _____________________Zip Code: ________________________

Email to receive information via secure email: ____

Phone Number: ____ Fax Number: ____

You may use/disclose the following information:

_____ All health care information in the patient 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 only – date(s): ____

_____ Specific information only (list): ____

I understand that the requested information may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, substance use disorder, genetic testing, mental illness, or psychiatric treatment***. I give my specific authorization for this information 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 _____ Genetic Testing
_____ Psychiatric disorders / Mental health treatment _____ Substance use disorder

Purpose of disclosure: _____ 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: ___________________________

I understand that I do not have to sign this authorization to get health care 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 I revoke this authorization, then Vancouver Clinic cannot undo disclosures already released under this authorization and may continue to make uses or disclosures under this authorization to the extent that it has already acted in reliance on this authorization.
I understand that 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 after I have signed it.

I understand there may be a <u>fee</u> associated with my request RCW 70.02.030, 45 CFR (171.302)

____ ____
Patient or legally authorized representative signature Date

____ ___________________________________
Relationship to Patient if signed on behalf of patient Printed name if signed on behalf of patient