Three Rivers Family Medicine, PSC

Authorization to Use or Disclose Protected Health Information

Patient name: _____Date of birth: _____

Previous name: _____

My Authorization: Name (or title) and organization or class of persons: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone:_____ Fax: _____

I. **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): _____

Uses and Disclosures Requiring Specific Authorization

You may use or disclose health care information regarding testing, diagnosis, and treatment for **(check all that apply):**

- □ HIV/AIDS
- □ Mental Health or Illness
- □ Reproductive Care (minors only)
- □ Sexually Transmitted Diseases
- □ Drug and/or Alcohol Abuse

Minors – *a minor patient's signature is required in order to disclose information related to reproductive care, sexually transmitted diseases (if age 14 and older), HIV/AIDS (if age 14 & older), drug &/or alcohol abuse (if age 13 & older), & mental health or illness (if age 13 & older).*

You may disclose this health care information to:

Three Rivers Family Medicine, PSC 945 Goethals Drive, Suite 300 Richland, WA 99352

Phone 509-943-3196 Fax 509-946-0455

This authorization ends:

- □ on (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)

II. My Rights

1. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits). However, I do have to sign an authorization form:
   - to receive research-related treatment in connection with research studies **or**
   - to receive health care when the purpose is to create health care information for a third party.
2. I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by **TRFM, PSC** in reliance on this authorization before it receives my written revocation. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
   - Fill out a revocation form—a form is available from **TRFM, PSC** or
   - Write a letter to **TRFM, PSC.**

III. Protection after Disclosure. I understand that once my health care information is disclosed, the person or organization that receives it may re-disclose it and that 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)

_____

Minor patient's signature, if applicable Date Time