Authorization to Use or Disclose Protected Health Information

Patient name: _____ Date of birth: _____

Previous name: _____

Information to be released from: _____

I. My Authorization

Rehabilitation Institute of Washington, PLLC 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. specific report)—specify date(s): _____

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.

EXCLUDE the following information from the records released (please initial):

_____ HIV/AIDS diagnosis/treatment/testing

_____ Sexually transmitted diseases

_____ Psychiatric disorders/mental health

_____ Drug and/or alcohol use

You may disclose this health care information to:

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

Phone: _____ Fax: _____

Address: _____

Reason(s) for this authorization to use or disclose my health care information (check all that apply):

□ at my request

□ other (specify) _____

□ for marketing purposes

□ check here if **Rehabilitation Institute of Washington, PLLC** will be paid for providing health care information for marketing purposes by the third party whose product or service is described in the marketing

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 **Rehabilitation Institute of Washington, PLLC** 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 **Rehabilitation Institute of Washington, PLLC** or
   - Write a letter to **Rehabilitation Institute of Washington, PLLC**.

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)

Updated: 9/16/2013