AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH CARE INFORMATION

Patient Name:_____ **DOB:**____/____/_____

At my request, please release my health care information

From:

Name/Organization:_____

Address:_____

City, State:_____ Zip:_____

Phone:_____ Fax:_____

To:

Name/Organization:_____

Address: _____

City, State:_____ Zip:_____

Phone:_____ Fax:_____

Release the following information:

☐ All health care information

☐ Health care information related to the following treatment or condition:_____

☐ Health care information from the date(s):_____

☐ Other (e.g., X-rays, bills) – specify date(s):_____

Reason for authorization: ☐ Personal Reasons ☐ Other:_____

Uses and Disclosures Requiring Specific Authorization: As an office policy we do not redact information contained in your file.
A separate authorization is required to release Psychotherapy notes. Psychotherapy notes are notes recorded by a mental health professional documenting or analyzing conversations during one or more private, group, joint, or family counseling sessions. By checking the box below you are authorizing the one-time release of this specific protect health care information.

☐ I hereby authorized the release of any psychotherapy notes contained within my record.

A specific authorization is required to use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

☐ HIV/AIDS ☐ Sexually Transmitted Diseases ☐ Mental Health or Illness

☐ Drug and/or Alcohol Abuse ☐ Reproductive Care (minors only)

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 and older), drug and/or alcohol abuse (if age 13 and older), and mental health or illness (if age 13 and older).

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)

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).
2. I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by Totem Lake Family Medicine, PLLC in reliance on the 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 Totem Lake Family Medicine, PLLC or
   - -Write a letter to Totem Lake Family Medicine, PLLC.

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.

I understand that signing this form is not a condition of my treatment at Totem Lake Family Medicine, PLLC.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed name (if signed on behalf of the patient) Relationship (parent, legal guardian, personal representative)

_____ _____

Minor patient's signature, if applicable Date