

Authorization to Use or Disclose Protected Health Information to LMC

Patient name: _____ Date of birth: _____

Previous name: _____

I. My Authorization

I request and authorize: _____

Name/Facility

Address

City/State/Zip

**To disclose health care information on the above named patient to: Lacey Medical Clinic, P.S.,
5602 Ruddell Road SE, Lacey, WA 98503, Phone: 360-438-0394/Fax: 360-493-0824**

- 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
- 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).

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

Attorney Transfer Doctor Personal Other _____

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 Lacey Medical Clinic, P.S. 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 Lacey Medical Clinic, P.S. or
 - Write a letter to Lacey Medical Clinic, P.S.

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