FAMILY HEALTH CENTERS
YOUR FAMILY, YOUR HEALTH, YOUR CHOICE

Authorization for Use or Release of Protected Health Information

Privacy Officer: 509-422-7600 or 800-660-2129

Patient Name: _____ DOB: _____ Date: _____

Please disclose the following information:

☐ The most recent 2 years of pertinent information – Chart notes, labs, x-rays and special tests

☐ All medical records

☐ Specific information - Please specify:

_____

*****The following items must be initialed to be included in the use and/or disclosure of other protected health information*****

_____ **HIV/AIDS/STD related information and/or records** _____ **Psychotherapy notes and/or records**

_____ **Genetic testing information and/or records** _____ **Drug/Alcohol diagnosis, treatment, referral information**

I direct and hereby authorize Family Health Centers to deliver the protected health information specified in this Authorization to the party or parties specified in the following medium, if available:

☐ Hardcopy Format, such as paper or fax

☐ Electronic Format, such as CD-ROM or flash drive (memory stick)

☐ E-mail

☐ No Format preference

I understand that electronic media, and delivery methods such as e-mail, pose certain risks to the privacy and security of my protected health information that may be beyond the control of Family Health Centers. I agree to assume such risks personally, and to hold Family Health Centers harmless in the event my protected health information is breached or compromised as a result of my directing and authorizing Family Health Centers to transmit or deliver such information electronically.

Purpose for disclosure: ☐ Doctor ☐ Personal Use ☐ Attorney ☐ Insurance ☐ Transfer of Care

<u>Health Information to be released FROM</u>:

Name (or class of persons) and organization: _____

Address: _____ City _____ State _____ Zip _____

Phone number: _____ FAX Number: _____

Health Information to be released TO:

Name (or class of persons) and organization:

_____

Address: _____ City _____ State _____ Zip _____

Phone number: _____ FAX Number: _____

Unless revoked earlier, this authorization will expire on or be in place until (insert applicable date or event)

_____

_____

I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to Family Health Centers, PO Box 1340, Okanogan, WA 98840. I understand that a revocation is not effective to the extent that Family Health Centers has relied on this Authorization for the use or disclosure of the Protected Health Information up to the time the revocation was received by the organization.

I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Family Health Centers will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the Protected Health Information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Have an electronic copy of my medical records, or a portion thereof, transmitted to any third party or person I designate.
- Refuse to sign this Authorization.

The use or disclosure requested under this Authorization will result in direct or indirect remuneration to Family Health Centers from a third party. (If applicable)

Signature of Patient or Personal Representative: _____ Date: _____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

☐ Beneficiary or personal representative of deceased patient

Special Note:

Minors: a minor patient's signature is required in order to release the following information: (1) conditions relating to the minor's reproductive care including, but not limited to, contraception, pregnancy and pregnancy termination, sterilization, and STI (age 14 and older); (2) chemical dependency and mental health conditions (age 13 and older)