

BIRTH & FAMILY CLINIC

21911 76th Ave. W., Suite #110 Edmonds, WA 98026
Phone: 425-640-4956 Fax: 425-640-4961

Authorization for Use or Disclosure of Protected Health Information (PHI)

Patient Name (PLEASE PRINT): _____ Date of Birth: _____

PHI Disclosed FROM: Birth & Family Clinic*

Name – (i.e. Health Facility, Lawyer, Physician...)

Phone # and/or Fax #

Address

City, State, Zip Code

PHI Disclosed TO: Birth & Family Clinic

Name – (i.e. Health Facility, Lawyer, Physician, Self...)

Phone # and/or Fax #

Address

City, State, Zip Code

Reason for Use/Disclosure:

Personal Records Transfer of Medical Care Other (specify): _____

Two-Way Release - By checking this box, I authorize the individuals/agencies named in this authorization, to disclose to each other, the information identified below on an ongoing basis for the duration of this authorization.

PHI Authorized for Use/Disclosure:

Most recent 2 years of pertinent information (chart notes, labs, x-rays, and special tests)

Entire Medical Record*

Other (specify): _____

I understand that my record may contain diagnosis, treatment, and testing or referral information for HIV/AIDS, sexually transmitted diseases (STD's), alcohol and/or drug abuse, mental health, or psychiatric disorders. I give my specific authorization for this information to be disclosed with my records, unless indicated otherwise below.

I do NOT authorize use/disclosure of the records that pertain to (please initial):

_____ HIV/AIDS _____ STD's _____ Alcohol/Drug Abuse _____ Mental Health/Psychiatric Disorders

PHI to be Disclosed Via:

Photocopy:* Mail Fax Call for Picked Up at: _____

Review by Patient: _____
An appointment for review must be scheduled. Please indicate preferred days and time.

Other (specify): _____

***If requesting copies of an entire record from Birth & Family Clinic:** I understand the record may be voluminous and agree to pay all reasonable charges associated with Birth & Family Clinic providing this record.

I understand I do not have to sign this authorization in order to obtain health care treatment. I understand that I may revoke this authorization **in writing** at any time, providing the information has not been already disclosed. I understand that once my information is disclosed, it is subject to re-disclosure and may no longer be protected.

This authorization is valid for 90 days from the date of signing unless revoked earlier or specified otherwise: _____.

SIGNATURE: X _____ **DATE:** _____
(Patient/legal representative signature)

(If patient is not signing, indicate representative's authority to act on patient's behalf (e.g., legal guardian))