Authorization to Use or Disclose Protected Health Information

Patient name: _____ Date of birth: _____

Previous name: _____

I. My Authorization

Dermatology and Laser Center North West 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., 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

Note: State law may require that other types of information are more highly protected and require express authorization for use or disclosure. Consult legal counsel to learn what types of information are highly protected in your state and thus require express authorization, and incorporate those requirements into your organization's Authorization form.

Minors—a minor patient's signature is required in order to disclose information related to:

(1) _____, at age __
(2) _____, at age __
(3) _____, at age __
(4) _____, at age __

Note: Under state law, minors may have the right to consent to certain types of care at certain ages, without parental consent, and in those cases, generally only the minor may authorize the use and disclosure of the related medical records information. Consult legal counsel to learn when a minor's authorization may be needed and incorporate those requirements into your organization's Authorization form.

You may disclose this health care information to:

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

Phone:_____Fax:_____

Address (optional): _____ City: _____ State: ___ Zip: _____

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

- □ at my request
- □ for marketing purposes
  - □ check here if **Dermatology and Laser Center NW** will be paid for providing health care information for marketing purposes by the third party whose product or service is described in the marketing
- □ research (describe one or more research studies) _____
- □ other (specify)_____

This authorization ends:

□ on (date): _____ or when the following event occurs: _____

If an expiration date or event is not specified above, this authorization ends 6 months after the date signed.

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 **Dermatology and Laser Center NW** 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 Dermatology and Laser Center NW or
   - Write a letter to Dermatology and Laser Center NW.

III. Protection after Disclosure. I understand that once my health care information is disclosed, the person or organization that receives it may redisclose 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