Authorization to Use or Disclose Protected Health Information (PHI)

Patient name: _____Date of birth: _____ MRN: _____

I. My Authorization (Patient requesting PHI from another facility to share with providers at Dermatology and Laser)

Dermatology and Laser Center NW may request and use or disclose the following health care information from (Facility PHI requested from)

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

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

Facility fax number: _____

Please fax or mail to: Dermatology and Laser Center NW, 905 Squalicum Way, Ste. 101, Bellingham, WA 98225 or Fax: 360.676.0377

(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
□ Mental health or illness
□ Sexually transmitted diseases
□ 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 _____

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 my health care information to: (Patient requesting we send PHI from Dermatology and Laser to another provider):

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

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

Facility fax number: _____

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

□ at my request
□ for marketing purposes
□ 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