Authorization to Use and Disclose Health Information

Patient Name: ______________________ Date of Birth______________ Date:____________

Phone:______________________________

I authorize: London Health Center
2376 Main Street
Ferndale, WA 98248
(360) 384-2900 *fax* (360) 384-2955

OR

This other entity (name/address of recipient)
____
____
____

To use and/or disclose a copy of the health information described below for the above-named patient

Health information is to be received and used by:
London Health Center
2376 Main Street
Ferndale, WA 98248
(360) 384-2900 *fax* (360) 384-2955

OR

This other entity (name/address of recipient)
____
____
____

For the purpose(s) of:
At the request of the patient or legal/person representative
Other purposes (specify each purpose): ______________________________

Description or nature of information to be used and/or disclosed: *(check all that apply)*

□**Pathology reports**
□**Radiology & imaging reports**
□**Laboratory reports**
□Operative reports
□Clinician office notes
□Physician/ARNP progress notes
□Discharge summaries
□Consultations
□Medication records
□ EKG reports
□ Emergency Dept. records
□ Specially Protected Information:
□ *Mental health treatments records*
□ *Drug/Alcohol abuse diagnosis, treatment, referral records*
□ *Information re: HIV / AIDS / Sexually transmitted diseases*
□ *Information re: Genetic Testing (Oregon)*
□Other records (specify): ______________________________
□All health records for the above named entity (Excludes the above Specially Protected Information unless box(es) checked)

1. I understand that, if the recipient of the information disclosed under this authorization is not a health plan or provider covered by federal or state privacy laws, the information may be re-disclosed by the recipient and no longer protected by those laws. If the information being disclosed under this authorization includes HIV/AIDS, Sexually transmitted Diseases, mental health, genetic testing, and drug/alcohol abuse diagnosis, treatment, or referral information, Federal law and regulation including 42 CRF Part 2 and 45 CFR Parts 160 and 164 or state law may prevent the recipient from re-disclosing this information.

2. I may refuse to sign this authorization. My refusal will not adversely affect my ability to receive treatment, to enroll in a health plan, to be eligible for benefits, or to obtain payment for services unless this authorization is sought for purposes of research-related treatment, to determine my eligibility or enrollment in a plan, for underwriting or risk determinations or if the services related to the information to be disclosed are performed solely for the purpose of providing that information to someone else.

3. I may revoke this authorization at any time by notifying the Health Information Management/ Medical Records Department of the above named entity on its designated form. However, any such revocation will not apply to any activity undertaken based on this authorization. London Health Center's Joint Notice of Privacy Practices also describes how to revoke this authorization.

4. I may request copy of this authorization. I may inspect or request copies information disclosed by this authorization.

Unless revoked, this authorization is valid for 90 days from the signature date below, or for the following time period:
Beginning date: ______________ Ending (expiration) date: ______________
(In Washington, the expiration date can be no later than 90 days after this authorization is signed if disclosure is to employer or financial institution.)

****SIGNATURE: I have read this authorization, and I understand it.***

______________________________ ______________
Signature of Patient or legal/personal representative Date:
Relationship to patient: ______________________________