Family Practice, PLLC
5130 Corporate Center Ct SE, Lacey, WA 98503 Phone: 360-413-8600 Fax: 360-413-8822

AUTHORIZATION TO USE AND DISCLOSE PATIENT INFORMATION

You have the right to review the provided Notice of Patient Practices before signing this form.

Printed Name of Patient: ______________________ **Date of Birth:** __________
Previous name(s) ______________________

I authorize my protected health information to be disclosed:

FROM: ______________________ **TO:** ______________________
FACILITY NAME **INDIVIDUAL OR FACILITY NAME**

______________________ ______________________
Address Address

______________________ ______________________
City, State & Zip City, State & Zip

______________________ ______________________
Phone # Phone#

______________________ ______________________
Fax # Fax #

Information to be released:

The most recent 2 years of pertinent information ____*AND/OR* The following specific information __________

Purpose for release of information: ______________________

I authorize the release of the following information (INITIAL THE FOLLOWING):

Patient must authorize specific information to be released, even if patient is a minor (see age requirements next to type of record).

Information related to diagnosis and treatment of sexually transmitted diseases (***14 yrs or older***) _____
Information related to diagnosis and treatment for any condition concerning to mental health (***13 yrs or older***) _____
Information related to diagnosis and treatment of HIV or AIDS (***14 yrs or older***) _____
Information related to diagnosis and treatment for drug and/or alcohol abuse (***13 yrs or older***) _____

I UNDERSTAND THAT INFORMATION OTHERWISE PROTECTED BY LAW AND DISCLOSED UNDER THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE, AND MAY NO LONGER BE PROTECTED BY LAW, INCLUDING BUT NOT LIMITED TO PRIVACY REGULATIONS ISSUED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

I understand that I may revoke this Authorization at any time by giving Pioneer Family Practice notice in writing. Revocation of my authorization for use and disclose of information related to drug and alcohol abuse treatment may be provided orally. I understand that this provider cannot condition treatment on my provision of this authorization.

By signing below I agree that my protected health information may be used or disclosed as described above.

Signature of Patient or Legally Authorized Representative: ______________________

Authority of Legally Authorized Representative: ______________________ Date: __________

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED.