sound family medicine

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Bonney Lake Clinic
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Authorization to Use or Disclose Protected Health Information

PATIENT AKA/FKA:_____Birthdate____/____/_____PHONE: (___)_____-_____

ADDRESS_____ City: _____ State: _____ Zip _____

Section A: Medical Information to be released:

☐ You may use or disclose health care information recorded in the last 2 years
☐ If requesting records other than the most recent 2 years, please specify timeframe here _____.
☐ Health care information specifically related to the following treatment (e.g., X-rays, bills) or condition- specify date(s):
_____

Section B: Information protected by State and Federal law:

☐ **Records as indicated above, including**

- HIV/AIDS
- Sexually Transmitted Disease
- Mental Health or Illness
- Drug and/or Alcohol Abuse
- Reproductive Care

or

☐ **Records as indicated above, except those check-marked below:**

☐ HIV/AIDS
☐ Sexually Transmitted Diseases
☐ Mental Health or Illness
☐ Drug and/or Alcohol Abuse
☐ Reproductive Care

Minors – a minor's signature is required in order to disclose information related to reproductive care (at any age), sexually transmitted diseases (14yrs and older), HIV/AIDS (14yrs and older), drug and/or alcohol abuse (13yrs and older), and mental health or illness (13yrs and older).

Section C: Disclosure Details:

Please obtain my health care information **FROM:**
ALL FIELDS REQUIRED
Sender Name: _____
Address: _____
City State Zip: _____
Phone: _____Fax: _____

Please disclose my health care information **TO:**
ALL FIELDS REQUIRED
Recipient Name:_____
Address: _____
City State Zip: _____
Phone: _____ Fax: _____

This authorization ends: ☐ on (date): _____ ☐ when the following event occurs (death, age, etc)_____
Purpose of disclosure: ☐ Attorney ☐ Insurance ☐ Doctor ☐ Personal ☐ Transfer of Care ☐ Other _____
Requested form of records: ☐ Electronic disk ☐ Printed ☐ No records at this time (Authorization for future requests or verbal disclosure)
Delivery Method: ☐ Pick up at _____ ☐ Mail ☐ MySFM Portal-(only limited records can be submitted to the portal.
If we are unable to satisfy this request we will contact you to receive your records alternatively)

Section D: Authorizing Signature:

My Rights:
1. I understand that I'm not required to sign this authorization in order to receive health care services and 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 Sound Family Medicine 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 Sound Family Medicine) or write a letter to Sound Family Medicine.

Protection after Disclosure: I understand that once my health care information is disclosed, the person or organization that receives it may re-disclose 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)

----------Internal Use only----------

Records Rec'd by _____WSDL/ID#:_____Verified by _____Date_____