**Authorization for Federal Way Pediatric Associates to Obtain My Health Care Information**

**Patient Name: Date of Birth:**

**Previous Name:**

**My Authorization**

**You 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, etc.), specify date(s):

**You may use or disclose health care information regarding testing, diagnosis and treatment for (check all that apply):**

* HIV (AIDS virus)
* Psychiatric disorders/mental health
* Sexually transmitted diseases
* Drug and/or alcohol use

**You may obtain health care information from:**

Name (title) and organization:

Address:

City: State Zip:

Phone Number: Fax Number:

**Reason(s) for this authorization (check all that apply):**

* Changing providers
* Other (Specify):

**This authorization ends:**

(This document does not permit disclosure of health information created more than 90 days after the date it is signed)

* In 90 days from the date signed
* On (date)
* When the following event occurs:

**My rights**

I understand I do not have to sign this authorization in order get health care benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form:

* To take part in a research study or
* To receive health care when the purpose is to create health care information for a third party

I may revoke this authorization in writing. If I do, it does not affect any actions already taken based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. One way to revoke this authorization is to:

* Write a letter to the FEDERAL WAY PEDIATRIC ASSOCIATES

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized signature Date

Printed name if signed on behalf of the patient Relationship