AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Identification
Printed Name: _____ Date of Birth _____
Address: _____
Telephone: _____

Information to Be Released – Covering the Periods of Health Care
From (date) _____to (date) _____

Please INITIAL type of information to be released:
___Entire Medical Record ___ Patient Registration Data ___ Billing Record ___ Other _____

INITIAL Purpose of Request:
___ Change of Provider ___ Continuity of Care ___ Relocation
___ Change of Insurance ___ Provider not on Panel ___ At the Patient's Request
___ Other _____

I do	INITIALS	I do not	Authorize the release of information related to: Please INITIAL below.
☐		☐	HIV Infection or AIDS _____
☐		☐	Mental Health Information/Records _____
☐		☐	Drug/Alcohol Diagnosis, treatment and/or referral information (see description below)

I, the undersigned authorize and request Rose Urgent Care and Family Practice to
____ Release Information to ____ Obtain information from (Please INITIAL option)
**Provider/Clinic _____Phone/Fax # _____
Address _____
Drug and/or Alcohol Abuse, and/or Psychiatric, and/or Psychological Care, and/or HIV/AIDS Records ReleaseI understand that my medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care, psychological care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, and/or other sensitive information. I agree to its release. I understand that if I authorize the release of Drug & Alcohol Abuse treatment records (such as from Center for Addictions) that those records are protected by Federal Law. The Authorization for Release of Information form does not authorize redisclosure of medical information beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug abuse, prohibit information disclosed from records protected by this law from being redisclosed, even to the patient, without the specific written consent of the patient or as otherwise permitted by such law and/or regulations. A general authorization for release of medical or other information is NOT sufficient for these purposes. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Time Limit & Right to Revoke Authorization
Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at 650 N Devine Rd STE B Vancouver WA 98661
Unless revoked, this authorization will expire on the following:
(Circle one) One year/ 6 Month/ Other:_____ from date of signature.

Re-disclosure
I understand that once information is released to the above person or persons, my information may be subject to re-disclosure. I understand that once information is released, it may be re-disclosed by the recipient and no longer protected by federal privacy regulations. I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless it is for research-related treatments or provided solely to give information to a third party as specified under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. I authorize Rose Urgent Care and Family Practice to use and disclose the protected health information specified above.

Signature: _____ **Date**: ____/ _____/ _____
(Patient, parent if minor child, or legal guardian)

Relationship to Patient: _____