Authorization and Request to Release Protected Health Information

Patient name: _____ Date of birth: _____

Previous name: _____

I. Authorization to release Protected Health Information: Information to be released from:

Name (or title) and organization: _____

Address (optional): _____ City: _____ State: ___ Zip:_____

Information to be released (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)—specify date(s): _____

Information to be released to:

Sound Clinical Medicine, PS, 6718 144th Street NW, Gig Harbor, WA 98332; Phone 253-857-6166; Fax 253-851-6333

Uses and Disclosures Requiring Specific Authorization: You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

- ☐ HIV/AIDS
- ☐ Mental Health or Illness
- ☐ Reproductive Care (minors only)
- ☐ Sexually Transmitted Diseases
- ☐ Drug and/or Alcohol Abuse

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

Reason(s) for this authorization to use or disclose my health care information (check all that apply):

☐ at my request ☐ for insurance or legal purposes ☐ other (specify)_____

This authorization ends:

- ☐ on (date): _____ ☐ when the following event occurs: _____
- ☐ in 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes other than payment)

II. My Rights

1. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits). However, I do have to sign an authorization form 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 Clinical Medicine, PS** 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: (1) Fill out a revocation form—a form is available from **Sound Clinical Medicine, PS** or (2) Write a letter to **Sound Clinical Medicine, PS**.

III. Protection after Disclosure. Sound Clinical Medicine, PS will protect the health care information received.

_____

Patient or legally authorized signature Date Time

_____

Printed name (if signed on behalf of the patient) Relationship (parent, legal guardian, personal representative)

_____

Minor patient's signature, if applicable Date Time

Sound Clinical Medicine, PS
6718 144th Street NW
Gig Harbor, WA 98332