Authorization for Use or Disclosure of Protected Health Information

Name:	DOB:	ID#:
Date/Time:	Allergies:	Gender:

Completion of this document authorizes the disclosure and/or use of individually identifiable protected health information (PHI). All sections of the form must be completed to be valid.

I authorize:

□ Wellpath at _____ (County/State)

□ _____ (Name/Address/Phone)

To disclose my health information to:

□ Wellpath at _____ (County/State)

□ Physician □ Attorney □ County Public Health □ Self

□ Other _____

At the following address:

Name/Company: _____

Address: _____

Phone/Fax: _____

Description of information to be released:

□ All Records (excluding protected class) □ Discharge Summary

□ Pharmacy records □ Radiology Reports □ Other: _____

Protected Class Information: Special approval is required before protected classes of information can be released. These types of records may or may not be contained in the medical records. This information will be disclosed only if I place my initials in the applicable space next to the type of information:

_____ Drug and Alcohol Records, diagnosis, treatment, or referral information

_____ Mental Health Records, including provider notes

_____ HIV/AIDS related information and testing

_____ Genetic testing information

_____ Minor's family planning and pregnancy information

The purpose or need for the disclosure of this information is:

□ Treatment or Consultation □ Continuity of Care □ At patient request

□ Marketing*

**Marketing disclosure will/will not result in direct or indirect remuneration to health care provider.*

This authorization will be valid for the time below unless it is revoked in writing by the patient.

□ One (1) year from signature date □ Completion of this request (one time disclosure)

□ On specific date _____ □ _____

You may revoke this authorization in writing at any time by sending a notice canceling this authorization to the provider(s) listed on page 1 of this form. Cancelation of this authorization will not apply to information that has already be released based on this authorization. In Washington, this authorization shall expire 90 days after the date signed if disclosure is to a financial institution or employer for purposes other than payment.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal confidentiality law (HIPAA). (*California law prohibits recipients of these records from re-disclosure unless another authorization for such disclosure is obtained, or unless such disclosure is specifically required or permitted by law.)*

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment, payment, or to enroll or be eligible for benefits.

I understand that I have a right to receive a copy of this release upon my request.

Fees may be charged for copy services.

_____ _____

Signature of Individual Date

_____ Relationship: □ Parent

Signature of Authorized Representative □ Guardian

□ Conservator

□ _____