WASHINGTON ORTHOPAEDIC CENTER
DEDICATED EXCELLENCE
1900 Cooks Hill Rd., Centralia, WA 98531 · (360) 736-2889 · FAX (360) 736-3136

Authorization to Use or Disclose My Health Care Information

Patient name: _____ Date of birth:_____ S.S.#_____

Previous name: _____

Release Records from:_____
Name, (or title) organization, city, state and zip code

I. 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), specify date(s):_____

You may NOT use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

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

You may disclose this health care information to:

Name (or title) and organization: _____
Address: _____ City: _____ State:_____ Zip: _____

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

☐ at my request
☐ other (specify) _____
☐ check only if Wash Ortho Ctr requests the authorization for marketing purposes
☐ check only if Wash Ortho Ctr will be paid or get something of value for providing health information for marketing purposes

☐ **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: _____
(no longer than 90 days from date signed)

II. My Rights

I understand I do not have to sign this authorization in order to 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 did, it would not affect any actions already taken by Washington Orthopaedic Center based upon this authorization. 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 the Washington Orthopaedic Center Or
- Write a letter to the Washington Orthopaedic Center.

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 individual signature | Date | Time

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

* If the patient has reached their 14th birthday, only the patient may authorize disclosure relating to sexually transmitted disease.