INTERLAKE MEDICAL CENTER, PLLC

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To: _____

Address: _____ **Ph:** _____ **Fax:** _____

Authorization to Use or Disclose Protected Health Information to Interlake Medical Center, PLLC

Patient Name: _____ **Date of Birth:** _____

Previous Name: _____

I. Authorization

Interlake Medical Center, PLLC may use or disclose the following healthcare information (check all that apply):

- ❑ All health care information in my medical record
- ❑ Health care information in my medical records relating to the following treatment or condition: _____
- ❑ Health care information in my medical records for the date(s): _____
- ❑ Other (e.g., x-rays, bills), specify date(s): _____

Uses and Disclosure Requiring Specific Authorization

You may use or disclose health care information regarding testing, diagnosis, and treatment for

- ❑ 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).

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

- ❑ At my request
- ❑ For marketing purposes
- ❑ Check here if Interlake Medical Center, PLLC, will be paid for providing health care information for marketing purposes by the third party whose product or service is described in the marketing.
- ❑ Other (specify): _____

III. 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 (if disclosure is to a financial institution or an employer of the patient for purposes other than payment)
- ❑ On (date): _____
- ❑ When the following event occurs: _____

IV. My Rights

I understand 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 research-related treatment in connection with research studies **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 would not affect any actions taken by Interlake Medical Center, PLLC 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:

- Fill out a revocation form-a form is available from Interlake Medical Center, PLLC.
- Write a letter to Interlake Medical Center, PLLC.

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

_____

Patient or legally authorized individual signature **Date**

_____

Printed name if signed on behalf of patient **Relationship**

_____

Minor patients signature, if applicable **Date**

Last update on 06/07/2013