Authorization to Use or Disclose Protected Health Information

Eye Clinic of Bellevue ❖ 1300 116th Ave NE, Bellevue, WA 98004 ❖ Phone: (425) 454-7912 ❖ Fax: (425) 452-8720

Patient Name: ____

Date of Birth: ______________________ Previous Name: ____

I. My Authorization

Eye Clinic of Bellevue LTD PS 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): ____

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 □ Sexually Transmitted Diseases □ Mental Health or Illness

□ Drug and/or Alcohol Abuse □ Reproductive Care (minors only)

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).

You may (check one):

□ **Disclose this health information to:** □ **Receive this health information from:**

Name (or title) and organization or class of persons: ____________________________________

Address: ______________________________ City: ________________ State: ___ Zip: _________

Phone Number: ________________________ Fax Number: ____________________________

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

□ at my request □ 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 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.
2. I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by **Eye Clinic of Bellevue LTD 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:
   - Fill out a revocation form—a form is available from **Eye Clinic of Bellevue LTD PS** or
   - Write a letter to **Eye Clinic of Bellevue LTD PS**.

III. Protection after Disclosure.

I understand that once my 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 Time

____

Printed name / Relationship (if signed on behalf of the patient—i.e., parent, legal guardian, personal representative)

____

Minor patient's signature, if applicable Date Time