



Authorization to Use or Disclose Health Care Information

Date _____

Patient Name/Phone Number _____

Patient DOB _____

I hereby authorize:**To Release Information TO:**

Name of Disclosing Party _____

Name of Recipient _____

Address _____

Address _____

City/State/Zip _____

City/State/Zip _____

Patient or legally authorized individual**Date & Time of Signature****You may use or disclose the following health care information (check all that apply):**

- All health care information in my record to include all diagnoses and lab results. I also agree to the release of health care information regarding testing, diagnosis, and/or treatment for HIV (AIDS virus); sexually transmitted disease; psychiatric disorders/mental health issues; drug or alcohol use.
- Health care information relating to the following treatment or condition: _____
- Health care information for the following date(s): _____
- Other, specify date: _____

This Authorization is effective until:

⇒ 90 days from the date of this form.

⇒ Upon conclusion of a specified issue: _____

⇒ Until the following date: _____

⇒ Is this a Permanent Transfer of my record? **Y N****My Rights Regarding Disclosure of Health Care Information**

- ◆ I understand that my health information may be used to carry out treatment, sent to insurance carriers for payment, or for health care operations.
- ◆ I understand that I have the right to request WCP to restrict how my information is used. I also understand that WCP is not required to agree to such restrictions.
- ◆ I understand that unless a specific date is noted, this Authorization expires 90 days from the date entered above.
- ◆ I understand that I have the right to revoke this consent, except that the revocation would not affect any actions already taken based upon my original request.
- ◆ I understand that once health care information has been disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect this information.

I may cancel this authorization in writing as allowed by law. There are 3 ways to cancel this authorization:

1. Sign and date a Revocation form. This form is available from Reception or Medical Records.
2. Write, sign, and date a letter to WCP to cancel this Authorization.
3. Sign, date, and write "CANCEL" on this original form.

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