

Authorization for The Women's Clinic of Vancouver, P.S. to Use or Disclose My Health Care Information

Patient Name: _____ Date of Birth: _____

Previous Name: _____

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 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

I authorize _____

to release 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

check only if the Women's Clinic of Vancouver, P.S. requests the authorization for marketing purposes

other (specify)

check only if the Women's Clinic of Vancouver, P.S. 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 document if signed.)*

in 90 days from the date signed on (date): _____

when the following event occurs: _____

(no longer than 90 days from the 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 the authorization in writing. If I did, it would not affect any actions already taken by the Women's Clinic of Vancouver, P.S. 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 Women's Clinic of Vancouver, P.S.; or
- Write a letter to the Women's Clinic of Vancouver, P.S.

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

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship (parent, legal guardian, personal representative)