FORKS COMMUNITY HOSPITAL

530 Bogachiel Way – Forks, Washington
Phone (360) 374-6271 Fax (360) 374-5616
www.forkshospital.org

Authorization for [ ] 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)
- ☐ Psychiatric disorders/mental health
- ☐ Sexually transmitted diseases
- ☐ Drug and/or alcohol use

You may disclose this health care information to:

Name (or title) and organization: _____ Phone No.: _____

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

- ☐ At my request
- ☐ Other (specify): _____ _____
- ☐ Check only if request is for authorization for marketing purposes
- ☐ Check only if something of value or payment if obtained 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 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. 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; or
- Write a letter to the (practice/health care facility).

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, etc.)