

Authorization for _____ to disclose My Health Care Information

Patient Name: _____ Date of Birth: _____
Social Security #: _____ Claim Number: _____

1. My Authorization

You may use or disclose the following health care information (check all that apply):

- Health care information in my medical records for the date(s): _____
 Discharge summary History and Physical Exam Operative reports
 Lab results Other (e.g. x-rays, bills):

I understand that my records may contain Information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

You may disclose this health care information to:

**Spine Rehab Associates
319 S Washington AVE
Kent, WA 98032
Tel: (253) 850-9780 Fax: (253)850-6445**

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

- At my request Medical Legal Insurance
Other _____

This authorization ends when the following event/date occurs: _____

This authorization will end 90 days from date signed if no event or date is specified. (This document does not permit disclosure of health information to employers or financial institutions more than 90 days from date signed.)

2. 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 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 by this Clinic based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Once the hospital discloses health care information, 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

Printed Name if signed on behalf of the patient.