



Authorization to Use or Disclose Protected Health Information

Patient name: _____ Date of birth: _____

Previous name: _____

I. My Authorization

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

- checkbox All health care information in my medical record
checkbox Health care information in my medical record relating to the following treatment or condition:
checkbox Health care information in my medical record for the date(s):
checkbox Other (e.g., X-rays, bills)—specify date(s):

Uses and Disclosures Requiring Specific Authorization

You may NOT use or disclose health care information regarding testing, diagnosis, and treatment for (initial all that apply):

- checkbox HIV/AIDS checkbox Sexually Transmitted Diseases
checkbox Mental Health or Illness checkbox Drug and/or Alcohol Abuse
checkbox 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 disclose this health care information To / From: (PLEASE MAIL IF MORE THAN 50 PAGES)

NorthShore Medical Group
P.O. Box 1519
White Salmon, WA 98672
Ph: 509.493.9539 Fx: 509.493.9538

You may disclose this health care information To / From:

Name (or title) and organization or class of persons:
Address: City: State: Zip:
Phone #: Fax # :

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

- at my request
- for marketing purposes
- check here if **NorthShore Medical Group** will be paid for providing health care information for marketing purposes by the third party whose product or service is described in the marketing
- 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 **NorthShore Medical Group** 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 **NorthShore Medical Group** or
 - Write a letter to.

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 (if signed on behalf of the patient) Relationship (parent, legal guardian, personal representative)

Minor patient's signature, if applicable Date Time