

N.E. Washington Health Programs

Medical Clinics

Chewelah Community Health Center
Kettle River Community Health Center
Lake Spokane Community Health Center
Loon Lake Community Health Center
Northport Community Health Center
Selkirk Community Health Center
Springdale Community Health Center

Dental Clinics

Colville Community Dental Clinic
Lake Spokane Community Dental Clinic
Springdale Community Dental Clinic

AUTHORIZATION TO USE OR DISCLOSE HEALTH CARE INFORMATION

PLEASE PRINT:

I, _____, hereby authorize release of my medical/dental information
for the time period of _____ to _____.

From: _____ To: _____

Regarding (Patient's Last Name): _____ First _____ MI _____

Birthdate: _____ Social Security #: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

YOU MAY USE OR DISCLOSE HEALTH CARE INFORMATION REGARDING TESTING, DIAGNOSIS
AND/OR TREATMENT FOR: *(Check all that apply)*

- | | | |
|---|--|--|
| <input type="checkbox"/> Complete Chart | <input type="checkbox"/> Diagnostic Tests (2 yrs prior) | <input type="checkbox"/> Consults |
| <input type="checkbox"/> Problem List | <input type="checkbox"/> Operative & Procedure Reports | <input type="checkbox"/> Hospital H&P and Discharge Summary |
| <input type="checkbox"/> Medication List | <input type="checkbox"/> Radiographs | <input type="checkbox"/> Psychiatric Disorders/Mental Health |
| <input type="checkbox"/> HIV (AIDS Virus) | <input type="checkbox"/> Sexually Transmitted Disease(s) | <input type="checkbox"/> Drug and/or Alcohol Use |
| <input type="checkbox"/> Other: _____ | | |

THE PURPOSE FOR WHICH THIS DISCLOSURE IS BEING MADE IS: *(Please check one of the following)*

- Attorney* Insurance* Doctor Personal*

* Please be aware that medical record copy charges may apply.

THIS AUTHORIZATION ENDS:

- In 90 days from date signed On (date): _____
 When the following event occurs (within 90 days of the signing date): _____

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MY RIGHTS:

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). This authorization will expire **90 days** from the date signed. 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.
- To participate in a research study or marketing practices.

I understand that the confidentiality of these records will be protected by **N.E. WASHINGTON HEALTH PROGRAMS**. These records cannot be disclosed without written consent, except as provided for under Federal or State of Washington laws. I may revoke this authorization in writing. If I do, it will 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 of Authorization to Use or Disclose Health Care Information form. A form is available from **N.E. WASHINGTON HEALTH PROGRAMS**.
- Write a letter to **N.E. WASHINGTON HEALTH PROGRAMS**.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. I release **N.E. WASHINGTON HEALTH PROGRAMS** of any liability if the recipient of disclosed information from this authorization inadvertently or purposely disclosed it.

I understand that my **EXPRESS CONSENT** is required for **N.E. WASHINGTON HEALTH PROGRAMS** to release information relating to sexually transmitted diseases, HIV/AIDS, contraception, pregnancy, sterilization, mental health conditions and/or drug/alcohol abuse. If I have been tested, treated or diagnosed in connection with any of these conditions, **N.E. WASHINGTON HEALTH PROGRAMS** is **SPECIFICALLY** authorized to release to the person or entity named above all information of medical/dental records relating to such diagnosis, testing or treatment.

As required by law, a patient who has reached his or her fourteenth birthday may authorize disclosure in connection with treatment of the above mentioned conditions. Minors have statutory and case law protection of their right to privacy regarding these decisions pertaining to their own bodies and health care, and the above information will not be released to anyone, including their parents or legal guardian, without his or her consent.

User or Legally Authorized Representative Individual Signature

Date

Time

Printed Name if Signed on Behalf of the Patient

Relationship (Parent, Legal Guardian, Etc.)