AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is used to authorize the release of protected health information in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide *all* information requested may invalidate this authorization.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I, _____ hereby authorize _____ _____ [surgeon name] to release the records identified on Exhibit A to this Authorization for Release of Protected Health Information. I agree to be responsible for all photocopying charges associated with the reproduction of such records.

This Authorization for Release of Protected Health Information applies only to the release of the records identified on Exhibit A. Such records should be released to _____

_____

[name and address of recipient]

for the following purpose(s): _____ _____.

I understand that providing my authorization is voluntary. I need not sign this Authorization for Release of Protected Health Information to continue to receive healthcare treatment from _____ _____ [surgeon name]. I understand that I may revoke this authorization, in writing, at any time except to the extent that disclosure was made prior to the time I revoked this authorization. I further understand that I may inspect and receive copies of the information to be disclosed.

I understand that the health records and information disclosed, or some portion thereof, may be protected by the federal Health Insurance Portability and Accountability Act ("HIPAA"). I further understand that it is possible that the information described above may be re-disclosed by the recipient and may no longer be protected by HIPAA. I further understand that my records may be protected under state law and, if so, cannot be disclosed without my written consent unless otherwise provided for in the law and/or regulations. This Authorization for Release of Protected Health Information shall expire one (1) year from the date below.

My signature below acknowledges that I have read, understand, and authorize the release of the information described on Exhibit A.

[Name]_____ Date:_____

(CONTINUED)

EXHIBIT A

DESCRIPTION OF HEALTH INFORMATION SUBJECT TO AUTHORIZATION

By placing a check mark in the spaces below, I authorize the release of the following records pertaining to services from _____ to _____ [insert dates]:

- **___ Complete medical record (all information)**
- **___ All hospital/institution records (includes nursing records/progress notes)**
- **___ Transcribed hospital/institution records (includes surgical reports, history/physical exam, consultation reports, discharge summary reports)**
- **___ Laboratory reports**
- **___ Pathology reports**
- **___ Diagnostic imaging reports**
- **___ EKG/cardiac reports**
- **___ Physical/occupational therapy reports**
- **___ Billing statements**
- **___ Surgeon office/clinical records**
- **___ Implant information (including operative report)**
- **___ Photographs**

Release of the following information may be governed by additional laws. I understand and agree that this information will be disclosed only if I place my initials **in the applicable space next to the type of information:**

- **___ HIV/AIDS information**
- **___ Mental health information**
- **___ Genetic testing information**
- **___ Drug/alcohol diagnosis, treatment, or referral information**

RESTRICTIONS:

According to federal and state regulations, if the medical information requested relates to AIDS/HIV treatment or treatment in a federally recognized chemical dependency unit, then the information will be accompanied by a statement limiting disclosure to third parties as required by law.

I understand that if the person or entity that receives the information is not a health care provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I realize that the office and its employees have a responsibility to maintain the confidentiality of the medical records in its possession. I understand that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. The office will not be held responsible for any subsequent disclosure by the recipient of the health information. I release Louis D. Potyondy MD, and employees of any liability that may arise as a result of any subsequent disclosure of my health information by the recipient.

MY RIGHTS

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.[2]

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at anytime, but I must do so in writing and submit it to the following address: 801 Pacific Ave. Tacoma, WA 98402

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

I have a right to receive a copy of this authorization.[3]

Information disclosed pursuant to this authorization could be re-disclosed by the recipient.
If this box __ is checked, the requester will receive compensation for the use or disclosure of my information.[4]

SIGNATURE

Date:_____
Time: _____ am/pm

Signature: _____
(Circle one: patient / representative / spouse / financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient:

Witness:_____

1 If mental health information covered by the Lanterman-Petris-Short Act is requested to be released to a third party by the patient, the physician, licensed psychologist, social worker with a master's degree in social work or marriage and family therapist, who is in charge of the patient must approve the release. If the release is not approved, the reasons therefore should be documented. The patient could most likely legally obtain a copy of the record himself or herself and then provide the records to the third party, however.

2 If any of the HIPAA-recognized exceptions to this statement applies, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment, or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.

3 Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures.

4 The requester is to complete this section of the form.