Authorization to Use or Disclose My Health Care Information

Patient's full name (print): ______________________ **Date of Birth:** __________

Previous name (print): ______________________ **Phone Number:** __________

Reason for this Authorization: ______________________

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

- ❑ All records ❑ Last 2 years of records ❑ Last 3 years of records __________
- ❑ Immunization records: __________ ❑ Bills/Payment information: __________
- ❑ Permanently release all mammography images
- ☑ Other (specify specific days of service) Hoosier Services Inc.
- ❑ Proxy Access

Place a check mark next to each item below that you wish to INCLUDE in this disclosure:

- ❑ HIV (AIDS virus) *see reverse ❑ Sexually transmitted diseases
- ❑ Psychiatric disorders/mental health ❑ Drug and/or alcohol abuse

I authorize disclosure of my health care information noted above to: (If more than one see reverse):

Name of person or organization __________

Address 18032 Lemon Dr.

City Yorba Linda State CA Zip 92886 Phone 800.882.4156 Fax 800.882.4957

You may obtain my health care information noted above from:

Name of person or organization __________

Address __________

City __________ State ____ Zip ____ Phone __________

MULTICARE MEDICAL CENTER
MEDICAL RECORDS
P.O. BOX 5299
TACOMA, WASHINGTON 98415-0299

This Authorization Expires:

- ❑ Please include a date or event that you want this authorization to expire. (If none indicated, it will expire in 90 days from date signed.) Date/Event: __________
- ❑ Financial institutions and employers:
  When an authorization permits the disclosure of health care information to a financial institution or an employer of the patient for purposes other than payment, the authorization as it pertains to those disclosures shall expire ninety (90) days after the signing of the authorization, unless the authorization is renewed by the patient. Initials: __________

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. However, it would not affect any actions/disclosures already taken by MultiCare Health System based upon this authorization. I may not be able to revoke this authorization if its purpose is to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. The form is available from MultiCare Health System. **OR**
- Write a letter to MultiCare Health System.

Once MultiCare Health System discloses your health care information, the recipient may re-disclose your information and privacy laws may no longer protect your information.

CHARGES FOR INFORMATION

I understand that I may be charged a reasonable fee for the copies I have requested. A fee schedule is available from the Health Information Management Department.

__________ Patient or legally authorized individual signature __________ Date

__________ Authorized individual's printed name if signed on behalf of the patient __________ Relationship (parent, legal guardian, personal representative)

MULTICARE USE ONLY

❑ Call patient when complete ❑ Fax to physician ❑ Mail ❑ Request completed at clinic

Provide Copy to Patient

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