



**OLYMPIC**

INTERNAL MEDICINE, INC. P.S.

**Olympic Internal Medicine, Inc., P.S.**  
2620 Wheaton Way, Bremerton, WA 98310  
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**Authorization to Use or Disclose Protected Health Information**

Previous name: \_\_\_\_\_  
Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**I. My authorization: You may use or disclose the following health care information (check all that apply):**

- All health care information in my medical record.
- The last 2 years of records, all immunization records and any endoscopy and pathology reports provided by: \_\_\_\_\_
- Health care information in my medical record relating to the following treatment or condition: \_\_\_\_\_
- Health care information in my medical record for the date(s): \_\_\_\_\_
- Other (e.g. bills), specify date(s): \_\_\_\_\_
- All health care information provided by: \_\_\_\_\_

**You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):**

- HIV (AIDS virus)  Sexually transmitted diseases
- Psychiatric disorders/mental health  Drug and/or alcohol use

**You may disclose this health care information to:**

Name (or title) and organization: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

- transferring care  at my request  other (specify) \_\_\_\_\_

**This authorization ends:**

- on (date): \_\_\_\_\_ (not to exceed one year from date signed)

**If an expiration date is not specified above, this authorization ends 1 year after the date signed.**

**Please check one:      Leave copies at clinic: \_\_\_\_\_ Records to be mailed: \_\_\_\_\_ (Postage will be added to the price)**

**II. Fees:** Washington State and federal law does provide that a "reasonable" or "cost-based" fee may be charged.

**III. My Rights:** I understand 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 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 at any time. If I do, it would not affect any actions already taken by Olympic Internal Medicine, Inc., P.S. 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 Olympic Internal Medicine, Inc., P.S. or
- Write a letter to Olympic Internal Medicine, Inc., P.S., Attention: Privacy Officer.

Once health care information is disclosed, 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 Time

\_\_\_\_\_  
Printed name if signed on behalf of the patient

\_\_\_\_\_  
Relationship (parent, legal guardian, personal representative)