OLYMPIC
INTERNAL MEDICINE, INC. P.S.

Olympic Internal Medicine, Inc., P.S.
2620 Wheaton Way, Bremerton, WA 98310
(360) 377-3923 fax (360) 373-4988

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 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: Unless specifically excluded below, this authorization includes release of specially protected information including referral, diagnosis and treatment information related to: (Please check all that apply to **EXCLUDE** the information from authorization and disclosure):
☐ **Substance Abuse** ☐ **Mental Health Conditions** ☐ **Sexually Transmitted Diseases** ☐ **HIV/AIDS**

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)