

Authorization for Bellingham Family Health Clinic to Use or Disclose My Health Care Information

Patient name: _____ Date of birth: _____

Previous name: _____

I. My Authorization.

You may disclose this health care information to:

Name (or title) and organization: _____

You may disclose this health care information from:

Name (or title) and organization: _____

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

- All health care information in my medical record
- 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., X rays, bills), specify date(s): _____

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

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

- at my request
- other (specify)

This authorization ends: *(This document does not permit disclosure of health information created more than 90 days after the date it is signed.)*

- in 90 days from the date signed
- on (date): _____
- when the following event occurs: _____
(no longer than 90 days from date signed)

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship
(parent, legal guardian, personal representative)