|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Patient Name: | SSN: | | | |  | |
| Address: | City, State, Zip: | | | |  | |
| Previous Name: |  | | | |  | |
| 1. **My Authorization:** I hereby request and authorize: | |  | | | | |
| to disclose the following health care information (check all that apply): | | | | | | |
| All health care information in my medical record. | | | |  | | |
| Heath care information in my medical record relating to the following treatment or condition: | |  | | | | |
| Health care information in my medical record for the dates: | |  | | | | |
| Other (e.g., x-rays, bills), specify date(s): | |  | | | | |
| You may disclose health care information regarding testing, diagnosis, and treatment for (check all that apply): | | | | | | |
| HIV (AIDS virus) Psychiatric disorders/mental health Sexually transmitted diseases Drug and/or alcohol use | | | | | | |
| Reason(s) for this authorization (check all that apply):  At my request Other (specify): | | |  | | | | |
| This authorization ends:  90 days from the date signed  On (date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  When the following event occurs: | | |  | | | |
| (n | | | (no (No longer than 90 days from date signed) | | |

You may disclose this  
health care information to:

**Dean Chier, MD** 2611 NE 125th Street Suite 90 Seattle, WA 98125

Phone: (206) 906-9786 Fax: (206) 902-2008

1. **My Rights**

I understand I do not have to sign this authorization in order to get health care benefits. However, I do have to sign an authorization form:

* To take part in a research study
* To receive health care when the purpose is to create health care information for a third party

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by my provider based upon this authorization. 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 Dr. Chier’s clinic
* Write a letter to my provider revoking the authorization

Once health care information is disclosed, the person or organization that received it may re-disclose it. Privacy laws may no longer protect it.

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | |  |
| Patient or legally authorized individual signature | | Date | |
| Patient or legally authorized individual signature | | Relationship (parent, guardian, personal representative, etc.) | |