Dean Chier, MD

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Patient Name: Date of Birth:

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: _____
(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

2. **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 signature Date

Legally authorized individual signature Relationship (parent, guardian, personal representative, etc.)