Grove Street Family Clinic

Grove Street Family Clinic
1630 Grove Street
Marysville, WA. 98270
(360) 653-3500

AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION

LAST NAME OF PATIENT	FIRST NAME	MI	MEDICAL RECORD #
FORMER LAST NAME (if any)	FIRST NAME	MI	DATE OF BIRTH

HOME PHONE ( )	WORK PHONE ( )	DATE OF BIRTH	SOCIAL SECURITY NO.

I authorize the following organization to release information as stated below for the patient health information record.
This authorization covers the time period beginning ___/___/___ (date) and ending ___/___/___ (date).

INFORMATION TO BE RELEASED FROM:	**INFORMATION TO BE RELEASED TO:**
Grove Street Family Clinic	**Grove Street Family Clinic**
Organization/Person Name	Organization/Person Name
Street Address	Street Address
City, State, Zip	City, State, Zip
Telephone Number	Telephone Number

TYPE OF RECORDS REQUESTED (Charges for copies of records may be associated with your request)

Health care Information related to the following treatment or condition _____

_____

Laboratory/Diagnostic Tests _____

_____

Other

Sensitive Records require specific patient authorization.
Please initial the appropriate records requested:

___ Drug and/or Alcohol Abuse
___ Mental Health
(may include Pain Management or Pyschiatry records)
___ Sexually Transmitted Diseases (includes AIDS/HIV)

Purpose or Need for this Information: Continuing care (NO FEE) Copies for own use (FEE) Other _____

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective when Grove Street Family Clinic has already relied on the use or disclosure of the health information or if my authorization was obtained as a condition of obtaining Insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to the authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, or eligibility for benefits) except when (1) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party, or (2) an authorization is required for health plan eligibility or enrollment or a risk rating determination. Failure to sign an authorization may result in inability to obtain certain benefits in these cases.

I acknowledge I have fully reviewed and understand the contents of the authorization. My signature below indicates that I hereby agree and authorize to release of patient health information to the above named person or organization.

_____ _____ _____
Date (mo/day/yr) Signature of Patient or Legally Responsible Party Authority to sign, if not Patient

This authorization is not valid to release future health care information more than (1) year from the date signed (except to payer or as otherwise permitted under law). It will expire in 180 days unless otherwise specified_____ (date/event).