Authorization for: _____
to Use or Disclose My Health Care Information

Patient Name:_____ Date of Birth:_____

Previous Name : _____

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 to include HIV (AIDS virus), Sexually transmitted diseases, Psychiatric disorders/mental health, drug and/or alcohol use.
- ❑ 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. labs, X-rays, bills), specify date(s):_____

Specifically exclude the following:

- ❑ HIV (AIDS virus)
- ❑ Sexually transmitted diseases
- ❑ Psychiatric disorders/mental health
- ❑ Drug and/or alcohol use
- ❑ Other _____

You may disclose this health care information to:

L. James Wagner, N.D.
119 N. Commercial, Suite 315, Bellingham, WA 98225 tel. 360-647-1831

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)

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). 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 3rd party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by [name of practice or health care facility] 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 the [practice/health care facility]. Or write a letter to the [practice/health care facility].
- 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)

Last Update:___/___/___