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Authorization for Interlake Medical Center, PLLC, to Use or Disclose My Health Care Information

Patient name: _____ Date of birth: _____

Previous name: _____

I. Authorization

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

You may disclose this health care information to:

Name (or title) and organization: _____

Address: _____ City: _____ State: _____ Zip: _____

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

- at my request
- other (specify) _____
- check only if Interlake Medical Center, PLLC, requests the authorization for marketing purposes
- check only if Interlake Medical Center, PLLC, will be paid or get something of value for providing health information for marketing purposes

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 third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Interlake Medical Center, PLLC 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 Interlake Medical Center, PLLC. Or
- Write a letter to Interlake Medical Center, PLLC.

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 _____

Printed name if signed on behalf of the patient _____ Relationship _____
(parent, legal guardian, personal representative)