SENDING RECORDS OUT

Authorization For My Healthcare Information to be Used or Disclosed from:

Dr. Jean R. Dydell
Dr. Chelsea Price
Dr. Mary T. Tsuang
Dr. Christina Tun

12303 N.E. 130th Lane Suite #230, Kirkland, WA 98034
425-899-5000 (phone) 425-899-5006 (fax)

Patient Name: ______________________ **Date of Birth:** ______________________
Previous Name: ______________________

I. My Authorization

You may use or disclose the following healthcare information (check all that apply):

___ All healthcare information in my medical record.
___ Healthcare information in my medical record relating to the following treatment or condition:
____
___ Healthcare information in my medical record for the date(s): ______________________
___ Other (e.g., X-rays, bills), specify date(s): ______________________

You may use or disclose healthcare information regarding testing, diagnosis, and treatment for (check all that apply):

___ HIV (AIDS)
___ Sexually transmitted diseases
___ Psychiatric disorders/mental health
___ Drug and/or alcohol use

Healthcare information to be disclosed to:

Name (or title) and organization: ______________________
Address: ______________________ City: ____________ State: ____ Zip: ________
Phone: ______________________ Fax: ______________________

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

___ at my request
___ check only if (practice/facility) requests the authorization for marketing purposes
___ other (specify) ______________________
___ check only if (practice/facility) will be paid or get something of value for providing health information for marketing purposes

This authorization does not permit disclosure of health information created more than:

___ 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 healthcare benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive healthcare when the purpose is to create healthcare information for a third party

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by Eastside OB/GYN 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 Eastside OB/GYN, or
- Write a letter to your doctor

Once healthcare 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, personal representative)

10/2020