Authorization for *Mill Creek Family Practice, PLLC* to Use or Disclose My Health Care Information

Patient name: _____ Date of birth: _____
Previous name: _____

I. My Authorization

You may disclose this health care information:

From: _____
_____
_____
_____

To: Mill Creek Family Practice
1025 153rd St SE Suite 200
Mill Creek, WA 98012
P: 425-338-4000
F: 425-338-4090

You may use or disclose the following health care information (check only one box):

☐ All health care information about me created by my provider.
I specifically consent to the disclosure of the following information, if applicable:

- Information about mental health diagnosis or treatment
- Information about diagnosis or treatment for alcohol or drug abuse
- Information about HIV/AIDS testing or treatment
- Information about diagnosis or treatment of sexually transmitted disease(s)

☐ All health care information about me *within the last two years* created by my provider.
I specifically consent to the disclosure of the following information, if applicable:

- Information about mental health diagnosis or treatment
- Information about diagnosis or treatment for alcohol or drug abuse
- Information about HIV/AIDS testing or treatment
- Information about diagnosis or treatment of sexually transmitted disease(s)

☐ All health care information about me as described in the preceding checkboxes, ***excluding*** the following:_____
☐ Specific health care information including only: _____

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

☐ At my request ☐ Other (please specify)_____

This authorization ends:

☐ 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 Mill Creek Family Practice, 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 Mill Creek Family Practice, PLLC ***Or***
- Write a letter to Mill Creek Family Practice, 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) Date Time