Authorization to Use or Disclose Protected Health Information

Patient Name: _____ Date of Birth: _____
Provider 1: _____ Phone: _____ Fax: _____
Provider 2: _____ Phone: _____ Fax: _____

I. MY AUTHORIZATION

You may disclose my information:

- ☐ Last chart notes, labs, physical/PAP/mammogram, imaging, EKG, and immunizations
- ☐ Medical records relating to the following treatment, dates, or conditions: _____
- ☐ Other (e.g., X-rays, bills, etc.) - specify dates: _____

Uses and Disclosures Requiring Specific Authorization

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

- ☐ HIV/AIDS
- ☐ Mental Health or Illness
- ☐ Reproductive care (minors only)
- ☐ Sexually transmitted diseases
- ☐ Drug and/or alcohol abuse

Minors - a minor patient's signature is required in order to disclose information related to reproductive care, sexually transmitted diseases (if age 14 or older), HIV/AIDS (if age 14 or older), drug and/or alcohol use (if age 13 or older), and mental health or illness (if age 13 or older).

You may disclose this information to:

HorizonView Health
1408 3rd St SE, Ste 200
Puyallup, WA 98372

ph: 253.268.3345
fax: 253.881.1490
info@HorizonViewHealth.com

Reason(s) for this authorization to use or disclose my health care information (check all that apply):

- ☐ At my request
- ☐ Other (specify): _____

This authorization ends:

- ☐ on (date): _____
- ☐ when the following event occurs: _____

II. MY RIGHTS

1. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits).
2. I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by **HorizonView Health** in reliance on this authorization before it receives my written revocation. 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 **or**
   - Write a letter to **HorizonView Health**.

III. PROTECTION AFTER DISCLOSURE

I understand that once my health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer protect it.

Signature - Patient or legally authorized individual signature (printed name if signed on behalf of the patient) Date