Masonboro Family Medicine, P.C.

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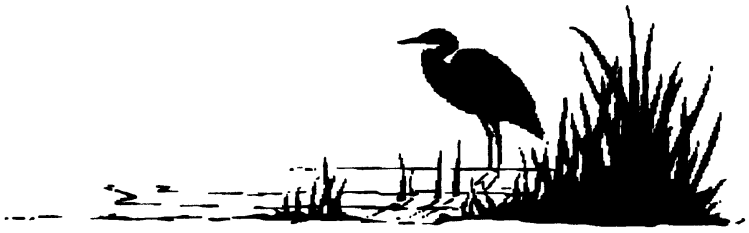

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____

I request and authorize _____
to release healthcare information of the patient named above to: _____

Purpose(s) or need: Information is to be used by the individual for:

☐ Treatment ☐ Benefits ☐ Legal ☐ Employment ☐ Other (Please specify) _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates

___Labs ___Last CPE ____ Last OV ____EKG ____CXR ____All records_____

☐ Other: _____

☐ All healthcare information ☐ Other

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Definition: Alcohol and/or drug treatment is protected by the federal law under the Drug Abuse Prevention, Treatment, and Rehabilitations Act and the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and their implementing regulations. *See generally 42C.F.R. Part 2; 45 C.F.R. Parts 160, 164.* I understand that my health information specified above will be disclosed pursuant to this authorization, that the recipient of the information may redisclose the information and it may no longer be protected by federal law under HIPAA. Federal Law governing confidentiality of alcohol and drug abuse patient information noted above, however, will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program from redisclosure. I understand that I may revoke this consent verbally or in writing at any time.

Revocation of Authorization

REVOCATION OF AUTHORIZATION TO DISCLOSE HEALTH INFORMATION IL 462-9401 (R-4-03) Page 1 of 1 The Health Insurance and Portability Act of 1996 (HIPAA), and the Mental Health and Developmental Disabilities (MHDD) Confidentiality Act provides an individual the right to revoke a previous authorization to disclose information at any time. By completing this form you are requesting a restriction to any further disclosures of your personal health information. I, (Print your name, address and phone number) hereby revoke any previous authorizations to disclose my protected health information. I understand that by signing below, revokes previous authorizations to disclose my protected information. I understand that no revocation of this consent shall be effective to prevent disclosure of records and/or communications until it is received by the person otherwise authorized to disclose records and communications. I further understand that the revocation will only apply to further disclosures or actions regarding my personal health information and cannot cancel actions or disclosures made while the disclosure was previously in effect and valid. I will retain a copy of the revocation form for personal reference, and the original will be kept on file in the medical record for the period of time designated for such retention.

This authorization expires one year after it is signed.

Patient Signature:_____ Date signed: _____

Print Name: _____

Witness Signature: _____ Date signed: _____

Print Name: _____