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1286 Mt Baker Rd, Suite B-102 • Eastsound, WA 98245
501 C3 Non-Profit Rural Health Center

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION - II

Patient's Name: _____ Date of Birth: _____

Social Security Number: _____ Other/Maiden Name: _____

I request and authorize the following use or disclosure of health care information of the above named patient from:

Name: _____ Name:_____

Address: _____ Address: _____

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

Fax:_____ Phone: _____ Fax:_____ Phone: _____

To be disclosed to: Orcas Family Health Center
1286 Mt Baker Rd., Suite B102
Eastsound, WA 98245

THIS REQUEST AND AUTHORIZATION APPLIES TO:

YES NO **ALL HEALTH CARE INFORMATION.**

YES NO **HEALTH CARE INFORMATION RELATING TO THE FOLLOWING CONDITION(S) OR DATE(S) OF TREATMENT: _____**

YES NO **OTHER: _____**

YES NO I understand that my express consent is required prior to the release of any health care information regarding Testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/ Mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV/(AIDS virus), Sexually transmitted diseases, psychiatric disorders/mental health, or drug/alcohol use, you are specifically Authorized to release all health care information relating to such diagnosis, testing, or treatment, legal obligations excluded.

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. I also understand that I may revoke this authorization at any time by signing a revocation form at Orcas Family Health Center and returning it to the Information Privacy/Security Officer. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

_____ Date Signed: _____
Signature of patient or patient's authorized representative

Relationship of person signing if other than the patient _____ Date Signed: _____

THIS AUTHORIZATION IS VALID FOR 90 DAYS