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Orcas Family Health Center
501(c)(3) Non-Profit Rural Health Center

Authorization to Release Healthcare Information - II

Patient's Name: _____ Date of Birth: _____

Social Security Number (Last 4 digits): _____ Other/Maiden Name: _____

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

Name: _____	Name: _____
Address: _____	Address: _____
City:_____ State: _____	City:_____ State: _____
Fax:_____Ph:_____	Fax:_____Ph:_____

To be disclosed to: Orcas Family Health Center (at the above address and contact numbers)

This Request and Authorization Applies to:

Yes No All healthcare information

-Or-

Yes No Only healthcare 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.

X _____ Date Signed: _____

Signature of patient or patient's authorized representative

Relationship of person signing if other than the patient _____

THIS AUTHORIZATION IS VALID FOR 90 DAYS Rev. 9/21/20