SURGICAL ASSOCIATES, P.L.L.C. 3610 ENSIGN RD NE OLYMPIA, WA 98506-5025
360/493-5252 Fax: 360/493-5257

Authorization to Release, Use or Disclose Protected Healthcare Information (PHI)

This form is to be used to request records only from Surgical Associates. It may not be used to request records from other medical facilities.

Patient's Name: _____ Date of birth: _____ SSN: _____

Previous Name(s): _____

Purpose of Disclosure: (Please check one)

❑ Myself ❑ Other provider/clinic ❑ Legal ❑ Other (specify) _____

I. MY AUTHORIZATION*:

Surgical Associates, PLLC is authorized by me to release, use or disclose the following healthcare information (check all that apply):

❑ ALL Records

❑ Date (s) or date range:

❑ Specific condition or treatment:

❑ Billing information

❑ Other _____

For Office Use Only
Date Records Sent: _____
Initials: _____

Pt ID:

RECEIVED

Surgical Associates, PLLC may disclose this healthcare information to (PLEASE FILL IN COMPLETELY):

❑ Mail to: ❑ Fax to: ❑ Hold for pickup by:

Name: _____ **Fax #:** _____

Address: _____
Street City State Zip

This authorization ends:

_____ on (specify date): _____

_____ in 90 days from the date signed (if disclosure is to a financial institution or an employer for purposes other than payment)

II. MY RIGHTS:

- I understand that I do not have to sign this authorization in order to receive health care treatment.
- I understand that I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by Surgical Associates, PLLC 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.
- I understand that my express consent is required to release any healthcare information relating to 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 and/or alcohol use, you are specifically authorized to release all healthcare information in relation to such diagnosis, testing, or treatment*.

I give my specific authorization for release/receipt of the following records:

Initial all that apply. I give specific authorization for release/receipt of sensitive diagnoses or treatments:

_____ Drug/Alcohol abuse diagnosis or treatment

_____ HIV/AIDS testing/diagnosis/treatment

_____ Sexually transmitted infections

_____ Mental Illness/Psychiatric diagnosis/treatment

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 of patient or patient's authorized representative* Date signed

_____
Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.).

** If the patient has reached his or her fourteenth (14) birthday, only the patient may authorize disclosures relating to sexuality/reproductive rights, HIV/AIDS. If the patient has reached his or her thirteenth (13) birthday, only the patient may authorize disclosure related to mental health treatment, and/or drug and/or alcohol abuse.*