# AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name_________________________________ DOB _____________ SS# _____________________
Address ____________________________________________________Phone (   ) __________________

I authorize **[provider name and address]** _______Kootenai Urgent Care_______to use and/or disclose my health information as identified below to:

☐ Patient at the same address above ☐ pickup ☐ mail ☐ fax: (   )______________________

☐ Other (include name or office, address, phone, fax) ________________________________________

_______________________________________________________________________________

Purpose(s): ☐At the request of the patient ☐Doctor/Continued Care ☐Attorney ☐Financial
☐Other as noted___________________________________________________

**By initialing the spaces below**, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist:

______Please send the entire medical record (all information) to the above named recipient.

______Medical records from __________ to __________ ______Billing statements

______Laboratory and/or Pathology reports ______Diagnostic imaging reports

______Other_______________________________________________________

Federal regulations require a description of how much and what kind of the following information is to be disclosed. The following items must be individually initialed to be included in the use or disclosure of other health information: Federal law prohibits the re-disclosure of such information.

______ *HIV / AIDS related health information and/or records
______ *Sexually Transmitted Disease information and/or records
______ *Birth Control/Pregnancy information and/or records
______ *Drug/alcohol diagnosis, treatment and/or referral information
______ *Mental health information and/or records
______ *Genetic testing information and/or records
______ Other ______________________________
______ *Restricted protected health information

Agreement must be terminated in writing or documented oral agreement to restrict disclosure.

____ ***Psychotherapy notes** (If this authorization is for the use and/or disclosure of psychotherapy notes, then it cannot be combined with any other authorization.)

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer of Kootenai Urgent Care. Unless revoked earlier, this authorization will expire 180 days from the date of signing or upon **[insert applicable date or event of expiration]** ______________________________. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by federal privacy laws or regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations. I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

SIGNATURE Patient_______________________________________________ Date _____________

Printed Name ______________________________________________________

If other than patient, indicate RELATIONSHIP: ☐ Parent ☐ Guardian ☐ Legal Representative ☐ Power Of Attorney

**Office Use Only**

Identity of patient and/or signature verified with: ☐ Photo ID ☐ Matching Signature ☐ Other ____________

Verified by (print): ____________________________________ Date: _________

Request completed by (print): _____________________________ Date: _________

Please allow at least 5 business days for records to be prepared. There may be a charge for these purposes.
A copy of this signed form can be provided to the individual and/or the individual's legal representative.

Revision: July 2010