AUTHORIZATION FOR TACOMA-PIERCE COUNTY HEALTH DEPARTMENT TO USE OR DISCLOSE MY HEALTH CARE INFORMATION

Patient/Client name: ____Date of birth: __________
Previous name: ____

I. My Authorization

You may use or disclose the following health care information:

☐ All/any health care information in my medical record
☐ Specific information in my medical record related to (specify):_____________________________________
____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

☐ HIV (AIDS virus)
☐ Psychiatric disorders/mental health
☐ Care and treatment received through Project Homeless Connect
☐ Pregnancy and/or parenting, including all nursing assessments and summaries
☐ Communicable disease
☐ Sexually transmitted diseases
☐ Drug and/or alcohol use
☐ Other *(specify):*_____________________
____

You may disclose this health care information to:

Service/Agency	Contact Person	Address

Reason(s) for this authorization (check all that apply):

☐ at my request
☐ check only if the Health Department requests the authorization for marketing purposes
☐ other (specify)

Unless I specify differently, this authorization will expire *(insert date or event)*:
____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study OR
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by Tacoma-Pierce County Health Department based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form OR
- Write a letter to the Tacoma-Pierce County Health Department.

I understand that once the Health Department discloses health care information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual's signature ______ Date ______ Time ______

Printed Name if signed on behalf of the patient ______ Relationship (parent, legal guardian, Executive of Estate, Health Care Power of Attorney) ______

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