Authorization to Use or Disclose Protected Health Information

Name ____

Date of Birth ____________________

Authorization to release records from:
______________________________ Phone: ______________ Fax: ______________

☐ Bryan C. McIntosh, MD

Please release the following health care information (check all that applies):

- ☐ All health care information in my medical record
- ☐ Health care information in my medical record relating to the following treatment or condition: ____
- ☐ Health care information in my medical record for the date(s): ______________________
- ☐ Other (e.g. x-rays, bills): ____

Health care information regarding testing, diagnosis, and treatment to be disclosed/released (check all that apply):

- ☐ HIV/AIDS
- ☐ Sexually Transmitted Diseases
- ☐ Mental Health or Illness
- ☐ Drug and/or Alcohol Abuse
- ☐ Reproductive Care (minors only)

Please disclose/release requested health care information to:
______________________________ Phone: ______________ Fax: ______________

☐ Bryan C. McIntosh, MD

Reason(s) for this authorization to use or disclose my health care information (check all that apply):

☐ At my request ☐ For marketing purposes, check here ☐ if ______________________ will be paid for providing health care information for marketing purposes by the third party whose product or service is described in the marketing

☐ Other: ____

This authorization ends:

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

My Rights

I understand that I do not have to sign this authorization in order to receive health care benefits (treatment, payment, enrollment, or eligibility for benefits). However, I do have to sign an Authorization to Treat form.

I may revoke this authorization at any time by sending written notification to Puget Sound Plastic Surgical Group, PLLC at PO Box 723, Kirkland, WA 98083. If I do, it will not affect any actions taken by Puget Sound Plastic Surgical Group, 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 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 be protected.

____
Printed name (if signed by parent, legal guardian, personal representative; circle title)

____
Signature Date Time

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