Cascade Surgeons
875 Wesley St, Suite 230, Arlington WA 98223
Phone 360-435-6097 Fax 360-435-1871

Authorization to Use or Disclose My Health Care Information

Patient Name ______________________________________ **Date of Birth**____________________

I authorize: ____________________________to use or disclose my healthcare information (check below all that apply)

You may use or disclose the following healthcare:

_ All healthcare information in my medical record

_ Healthcare information in my medical record for the date(s) ____________________.

_ Other (e.g., X -rays, bills), specify date (s) or condition(s) ___________________________________.

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

_ HIV (AIDS virus) _ Drug and/or alcohol use _ Sexually transmitted diseases _ Psychiatric disorders/mental health

You may disclose this healthcare information to:

Name/Organization____

Address____

Fax____

Reason (s) for this authorization

_ at my request
_ to transfer my healthcare records.
_ other ____

This authorization ends:

_ in 90 dates from the date signed
_ when the following event or date occurs:__________________________

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

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

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Cascade Surgeons based upon this authorization. I may not revoke this authorization if its purpose was to obtain insurance. To revoke the authorization, write a letter to Cascade Surgeons.

____ ______________________________

Patient or legally Authorized Individual Signature **Date**

____ ______________________________

Printed Name if Signed on Behalf of Patient **Relationship**