

AUTHORIZES THE FACILITY/PERSON YOU LIST BELOW TO RELEASE INFORMATION TO OUR OFFICE

Patient Name _____ Date of Birth _____ Previous Name _____

AUTHORIZATION

I authorize: Facility/clinic: _____ Provider/person: _____
 Address: _____
 Phone: _____ Fax: _____

To disclose health care information to:

- | | | |
|---|--|---|
| <input type="checkbox"/> Bellingham Bay Family Medicine
722 N State St
Bellingham, WA 98225
p 360.752.2865 f 360.647.8093 | <input type="checkbox"/> Island Family Physicians
2511 M Ave Ste A
Anacortes, WA 98221
p 360.293.9813 f 360.299.8605 | <input type="checkbox"/> North Sound Family Medicine
2075 Barkley Blvd Ste 105
Bellingham, WA 98226
p 360.671.3345 f 360.650.1354 |
| <input type="checkbox"/> Birch Bay Family Medicine
8097 Harborview Rd
Blaine, WA 98230
p 360.371.5855 f 360.371.5857 | <input type="checkbox"/> Lynden Family Medicine
1610 Grover St Ste D-1
Lynden, WA 98264
p 360.354.1333 f 360.354.5399 | <input type="checkbox"/> Squalicum Family Medicine
3015 Squalicum Pkwy Ste 120
Bellingham, WA 98225
p 360.676.9336 f 360.676.2567 |
| <input type="checkbox"/> Family Health Associates
3500 Orchard Pl
Bellingham, WA 98225
p 360.671.3900 f 360.647.0882 | <input type="checkbox"/> Medical Testing & Urgent Care Center
3130 Squalicum Pkwy
Bellingham, WA 98226
p 360.756.0382 f 360.756.5184 | <input type="checkbox"/> Whatcom Family Medicine
3015 Squalicum Pkwy Ste 160
Bellingham, WA 98225
p 360.671.4402 f 360.671.9463 |
| <input type="checkbox"/> Ferndale Family Medical Center
5580 Nordic Way
Ferndale, WA 98248
p 360.384.1511 f 360.384.5758 | <input type="checkbox"/> North Cascade Family Physicians
2116 E Section St
Mt Vernon, WA 98274
p 360.428.1700 f 360.848.4350 | |

You may use or disclose the following health care information (check all that apply):

- All health care information in my medical record *(see next section to release protected information)*
- Health care information in my medical record relating only to the following treatment or condition:

<input type="checkbox"/> Last year of lab report(s)	<input type="checkbox"/> Last DEXA report	<input type="checkbox"/> Immunizations
<input type="checkbox"/> Last pap report	<input type="checkbox"/> Last colon cancer screening report	<input type="checkbox"/> Problem list
<input type="checkbox"/> Last mammogram report		<input type="checkbox"/> Medication list
<input type="checkbox"/> Other: _____		
- Health care information in my medical record only for the date(s) of: _____
- Laboratory/X-Rays/Imaging: _____ Billing/Payment: _____

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

- HIV (AIDS virus)
- Mentally health or illness
- Reproductive health care – checking this box is needed to release information if the patient is under age 18 (per Washington State law).
- Sexually transmitted diseases
- Drug and/or alcohol use

Patient Name _____ Date of Birth _____

Minors – a minor patient's signature is required in order to disclose information related to reproductive care (*at any age*), sexually transmitted diseases (*age 14 and older*), HIV/AIDS (*age 14 and older*), drug and/or alcohol abuse (*age 13 and older*), and mental health or illness (*age 13 and older*).

AUTHORIZATION

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

- At my request
- Transfer of care
- Other (specify): _____
- For marketing purposes

This authorization ends:

- On a specific date: _____
- When the following event occurs: _____
- 90 days from the date signed
- When I cancel this authorization

My Rights

- A. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits). However, I do have to sign an authorization form:
- to receive research-related treatment in connection with research studies **or**
 - to receive health care when the purpose is to create health care information for a third party.
- B. I may cancel this authorization in writing at any time. If I do, it will not affect any actions taken by Family Care Network in reliance on this authorization before it receives my written cancellation. I may not be able to cancel this authorization if its purpose was to obtain insurance. To cancel this authorization:
- complete the box below
 - write a letter to Family Care Network

Protection after Disclosure

Information used or disclosed based on this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law.

Patient or legally authorized individual signature Date Time

Printed name (if signed on behalf of the patient) Relationship (*parent, legal guardian, personal representative*)

Minor patient's signature, if applicable Date Time

CANCEL THIS AUTHORIZATION

Patient signature: _____ Date: _____