SUMMIT VIEW CLINIC INC., P.S.
FAMILY PHYSICIANS

Authorization to Use or Disclose Protected Health Information

Patient name: _____ Date of birth: _____

Provider: _____ Phone:_____Fax: _____

I. My Authorization

You may disclose my information:

- ☐ All health care information in my medical record
- ☐ Medical records relating to the following treatment, dates or condition:_____
- ☐ Other (e.g., X-rays, bills)– specify date(s): _____

Uses and Disclosures Requiring Specific Authorization

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

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

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

You may disclose this health care information to:

Summit View Clinic
11019 Canyon Rd. E. Suite A
Puyallup, WA 98373

Phone:253-537-0293

Fax: 253-537-7650

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

- ☐ at my request
- ☐ other (specify) _____

This authorization ends:

- ☐ on (date): _____ ☐ when the following event occurs: _____

II. My Rights

1. 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).
2. I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by Summit View Clinic 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. Two ways to revoke this authorization are:
   - Fill out a revocation form or write a letter to Summit View Clinic.

III. Protection after Disclosure. 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 protect it.

Signature_____Date_____

Patient or legally authorized individual signature (Printed name if signed on behalf of the patient)