



# Respiratory Physicians of Southwest Washington

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## Authorization to use or disclose protected health information

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

### My Authorization:

**You may disclose this health care information to:**

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

### Please designate a primary number where we can contact you, and or leave a message containing pertinent private health information?

Home Phone \_\_\_\_\_  Cell Phone \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or legally authorized individual signature

### This Authorization ends:

This authorization is indefinite unless otherwise specified On (date): \_\_\_\_\_

### 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 did, it would not affect actions already taken by Respiratory Physicians of SW WA 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. A form is available from Respiratory Physicians of SW WA.
- **Or** write a letter to Respiratory Physicians of SW WA.

This authorization supersedes previous authorizations that are in the patient private health information.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.