TDC
THE DOCTORS CLINIC

Virginia Mason Franciscan Health™

MediCopy

A part of Franciscan Medical Group

Authorization for Use or Disclosure of Protected Health Information/Access to Protected Health
Attachment B

Information

I, _____, [Print name of Individual (i.e. patient, resident or client)] hereby authorize _____ [Insert entity] t ouse and/or disclose the individually identifiable health information as described below for the following patient:

Patient Name: _____ DOB: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

I authorize the following person(s) or organization to receive the information:

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ Email: _____

The following individually identifiable health information may be used and/or disclosed: Check (✓) all that apply:

- ____ All Records
- ____ Discharge Summary
- ____ Inpatient Records
- ____ Emergency Room Records
- ____ Complications and Procedures
- ____ Abstracts
- ____ Immunization (shot) Record
- ____ Outpatient Clinic Notes
- ____ Reports of Tests & X-rays
- ____ Face sheets with Final Diagnosis
- ____ Outpatient Records
- ____ Consultation Reports
- ____ History and Physical Records
- ____ Physical Therapy Notes

Other* _____

*If authorization is for marketing, indicate if The Doctors Clinic, a part of Franciscan Medical Group, will receive compensation in exchange for the use and/or disclosure of the PHI. ____ Yes ____ No

Dates of treatment to be released: _____

I request the form of the information be _____ Paper _____ Electronic (CD/DVD) _____ Electronic (Email)

Authorization for Use or Disclosure of Protected Health Information/Access to Protected Health
Attachment B

Information
page 2 of 3

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, psychiatric/mental health treatment and/or HIV-related conditions.

Reason or purpose fr the use and/or disclosure of the information:

I understand a fee may be charged for copies of my medical record.

Prohibition on Conditioning of Authorization: The Doctors Clinic, a part of Franciscan Medical Group, will not condition treatment on your signing this authorization unless:

- You are receiving research-related treatment, or
- The only reason th efacility is providing you with health care is to make a report to a third party, such as your employer (e.g. fitness to return to work) or school (e.g. P.E. physical).

Re-disclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of your health information may potentially re-disclose it. However, under the Federal Sustance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable sustance abuse information.

Expiration: This authorization will expire _____(insert date, event or “once purpose stated above is served”).

Revocation: I understand that I may revoke this authorization at any time by notifying The Doctors Clinic, a part of Franciscan Medical Group, in writing or completing the Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that The Doctors Clinic, a part of Franciscan Medical Group, took before it received my revocation letter. For example, The Doctors Clinic, a part of Franciscan Medical Group, cannot rescind disclosures it has already made and may use my health information as necessary to bil and collect for services rendered.

This Authorization is binding: The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in The Doctors Clinic, a part of Franciscan Medical Group’s Notice of Privacy Practices.

Authorization for Use or Disclosure of Protected Health Information/Access to Protected Health

Attachment B

Information

_____ _____

SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE **DATE**

Printed name of individual's personal representative, if applicable:

_____

Rationale for serving as personal representative to the individual (e.g. parent, legal guardian):

_____

FOR INTERNAL PURPOSES ONLY

When _____ [Insert CHI Entity] is requesting an authorization to use health information for its own use, the following provision must be completed:

Staff Personnel:

Received by: _____ Date: _____

Was a signed copy provided to the individual? ____ Yes ____ No

Access approved? ____ Yes ____ No