Authorization for Achieve Eye & Laser Specialists to Use or Disclose My Health Care Information

Patient Name: _____ Date of Birth: _____
Previous Name: _____

☐ **YOU MAY OBTAIN MY HEALTH CARE INFORMATION FROM**:
☐ **YOU MAY DISCLOSE MY HEALTH CARE INFORMATION TO:**

Name (or title) and organization: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

Information is to be: Picked up at our office _____ **Mailed to above address** _____ Faxed to above (if volume allows) ____

I. My Authorization

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

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

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

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

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

☐ at my request
☐ other (specify) _____
☐ check only if Achieve requests the authorization for marketing purposes
☐ check only if Achieve will be paid or get something of value for providing health information for marketing purposes

☐ **This authorization ends:** *(This document does not permit disclosure of health information created more than 90 days after the date it is signed.)*
☐ in 90 days from the date signed
☐ on (date): _____
☐ when the following event occurs: _____
(no longer than 90 days from date signed)

II. 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 any actions already taken by Achieve Eye & Laser Specialists 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 Achieve Eye & Laser Specialists. Or
- Write a letter to Achieve Eye & Laser Specialist at 3260 NW Mt. Vintage Way, Silverdale, WA 98383.

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

_____ _____
Patient or legally authorized individual signature Date Time

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