YAKIMA INTEGRATIVE HEALTH
https://www.yakimaintegrativehealth.com/
307 S 12 Ave, Ste. 9 Yakima, WA 98902
Phone: (509) 469-2483 | Fax: (509) 469-8870

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Name of Patient (printed) _____

Date of Birth _____ SSN _____

I. My Authorization

I authorize the following disclosing party:

Name (or title) of organization _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

To disclose the following health information:

- ○ All health information for the past 3 years
- ○ My health information relating to the following treatment or condition:

  _____
- ○ My health information covering the period from _____(date) to _____ (date)
- ○ Other: _____

The above party may disclose this health information to the following recipient:

Name (or title) of organization _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

The purpose of this authorization is (check all that apply):

- ○ At my request
- ○ Other: _____
- ○ To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so
- ○ To authorize the using or disclosing party to sell my health information. I understand the seller will receive compensation for my health information and will stop any future sales if I revoke this authorization.

This authorization ends:

- ○ On (date) _____
- ○ When documents are received

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA privacy standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorizations (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

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I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Date: _____

_____ _____
Patient's printed name Patient's signature

If the patient is a minor or unable to sign, please complete the following:

- Patient is a minor: _____ years of age
- Patient is unable to sign because: _____

Date: _____

_____ _____
Guardian/Legal Representative printed name Guardian/Legal Representative signature

_____
Relationship/Representative's Authority

III. Additional Consent for Certain Conditions

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment**. Separate consent must be given before this information can be released.

Does the patient or authorized representative consent to have the above information released? (please check)

- I consent to have the above information released
- I do not consent to have the above information released.

Date: _____

_____ _____
Patient's printed name Patient's signature

_____ _____
Guardian/Legal Representative printed name Guardian/Legal Representative signature

_____
Relationship/Representative's Authority

IV. Additional Consent for HIV/AIDS

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given before this information can be released.

Does the patient or authorized representative consent to have the above information released? (please check)

- I consent to have the above information released
- I do not consent to have the above information released.

Date: _____

_____ _____
Patient's printed name Patient's signature

_____ _____
Guardian/Legal Representative printed name Guardian/Legal Representative signature

_____
Relationship/Representative's Authority