

Steve Hutton, MD, PS; William Steven Hutton, MD, FAAP
1100 Basich Blvd, Aberdeen, WA 98520-1066
Phone: 360-532-1950 Fax: 360-537-1177

Authorization to Use or Disclose Health Care Information

Patient's full name (print): _____ Date of Birth: _____

Previous name (print): _____ Phone Number: _____

Reason for this Authorization: At my request **Transfer of Care** Other _____

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

All records Last 2 years of records Last 3 years of records _____

Bills/Payment information: _____

Other: Immunization Record, Medication List, Problem List, Last WC, Last Problem Visit, Specialist Reports

Place a check mark next to each item below that you wish to **INCLUDE** in this disclosure:

HIV (AIDS virus) Sexually transmitted diseases

Psychiatric disorders/mental health Drug and/or alcohol abuse

I authorize disclosure of my health care information by **Steve Hutton, MD, PS;**

W. Steven Hutton, MD to:

Name of person or organization: **Summit Pacific Medical Center**

Address: **600 East Main Street, Elma, WA 98541**

Phone: **360-346-2264** Fax: **360-346-2161**

THIS AUTHORIZATION EXPIRES IN 90 DAYS FROM THE DATE SIGNED UNLESS SPECIFIED BELOW:

Please include a date or event that you want this authorization to expire.

Date/Event: _____

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. However, it would not affect any actions/disclosures already taken by Steve Hutton, MD, PS; William Steven Hutton, MD based upon this authorization. I may not be able to revoke this authorization if its purpose is to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. The form is available from Steve Hutton, MD, PS. **OR**
- Write a letter to Steve Hutton, MD, PS

Once Steve Hutton, MD, PS discloses your health care information, the recipient may re-disclose your information and privacy laws may no longer protect your information.

If patient has reached his/her 13th birthday, and has consented to treatment, **ONLY** the patient can authorize disclosure relating to HIV/AIDS, Sexually Transmitted Diseases, Drug and/or Alcohol Abuse, or Mental Illness.

Parent or Guardian Signature

Patient if 13yrs or Older Signature

Date

Parent or Guardian Printed name

Patient Printed Name

Relationship (parent, legal guardian, foster parent, self)

Steve Hutton, MD, PS

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DRUG AND ALCOHOL ABUSE INFORMATION

Federal regulations (42 CFR Part 2) prohibit any further disclosure of this information except with specific written consent of the person to whom the information pertains or the parent or legal guardian of the minor child to whom it pertains (if the minor patient is 13 or older the minor patient's signature is required), unless otherwise permitted by federal law. A general authorization for the release of information is NOT sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

MENTAL HEALTH INFORMATION

State law prohibits any further disclosure of mental health information without specific written consent of the person to whom the information pertains, or the parent or legal guardian of a minor child to whom it pertains (if the minor patient is 13 or older the minor patient's signature is required), unless otherwise permitted by state law. A general authorization to release information is NOT sufficient for this purpose. (See RCW 71.05.390)

SEXUALLY TRANSMITTED DISEASE INFORMATION (Includes HIV/AIDS)

State law prohibits any further disclosure of this information without specific written consent of the person to whom the information pertains, or the parent or legal guardian of the minor child to whom it pertains (if the minor patient is 14 or older the minor patient's signature is required), unless otherwise permitted by state law. A general authorization to release information is NOT sufficient for this purpose. (See RCW 70.24 and WAC 246-100.)

***Note: Clinic Laboratories may not disclose HIV/AIDS result information directly to the patient. HIV/AIDS result information must be obtained from the provider that ordered the test:**

CONSENT FOR MINOR A minor patient's signature is required in order to release information concerning care for: (1) birth control and pregnancy-related care, (2) sexually transmitted disease information (including AIDS/HIV) if the minor is 14 or older, (3) substance abuse diagnosis or treatment if the minor is 13 or older, and (4) outpatient mental health information if the minor is 13 or older.

PROHIBITION ON REDISCLOSURE OF HEALTH INFORMATION

Federal and state laws prohibit re-disclosure of information concerning drug and alcohol abuse treatment, sexually transmitted diseases information, or mental health information without the specific written consent of the person to whom the information pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

To:

Name of person or organization _____
Address _____
Phone _____ Fax _____

To:

Name of person or organization _____
Address _____
Phone _____ Fax _____

Patient or legally authorized individual signature

Date

X _____

Authorized individual's printed name if signing on behalf of patient Relationship (parent, legal guardian, foster parent)

X _____