Steve Hutton, MD, PS; William Steven Hutton, MD, FAAP

1100 Basich Blvd, Aberdeen, WA 98520-1066
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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_____
❑ Immunization records:_____ ❑ Bills/Payment information:_____
❑ Other (specify specific days of Service):_____
❑ Proxy Access (Not Available for Foster Parents)

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

❑ HIV (AIDS virus) *see reverse ❑ 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. Steve Hutton, MD to:

Name of person or organization_____
Address_____
Phone_____ Fax_____

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.

CHARGES FOR INFORMATION

I understand that I may be charged a reasonable fee for the copies I have requested.

_____ _____
Patient or legally authorized individual signature **Date**

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

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_____