**Authorization to Use or Disclose Protected Health Information**

Patient name: _____ Date of birth: _____

**I Authorization to release records from:**

**_____Tel:_____Fax:_____**

**I.**

**Please release the following health care information (check all that applies)**

□ 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): _____

**Health care information regarding testing, diagnosis, and treatment to be disclose/release; (check all that apply)**

□ HIV/AIDS □ Sexually Transmitted Diseases

□ Mental Health or Illness □ Drug and/or Alcohol Abuse

□ Reproductive Care (minors only)

**Please disclose/release requested health care information to:**

Name and organization or class of persons:

- Kathy Partida,MD
- Katharine Barrett-Avendano ,DO

Address: 12301 NE 10th Pl, Suite 100, Bellevue, WA 98005

Telephone: 425-827-0100, E-fax 425-827-0166

**Reason(s) for this authorization to use or disclose my health care information (check all that applies):**

□ at my request

□ for marketing purposes

□ check here if **[_____]** will be paid for providing health care information for marketing purposes by the third party whose product or service is described in the marketing

□ other (specify) _____

**This authorization ends:**

□ in 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes other than payment)

**II. My Rights**

1. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits). However, I do have to sign an authorization form: party.
2. I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by **The Women's Center,PLLC** in reliance on this authorization before it receives my written revocation. I may not be able to revoke this authorization if its purpose was to obtain insurance.
   - Write a letter to **The Women's Center, PLLC if you wish to revoke this authorization.**

**III. Protection after Disclosure**. I understand that once my health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer be protected.

_____

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

Signature:_____Date:_____Time:_____