LAKE SERENE CLINIC
PRIMARY CARE & WALK-IN

AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION

I authorize the following parties to use and disclose a copy of the specific health/medical information described below.

Patient: _____ Phone: (_____) _____-_____ D.O.B.: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

Information to be used/disclosed: _____

Purpose of disclosure: _____

To / From: (circle one)
Lake Serene Clinic
3501 Shelby Road - Suite B
Lynnwood, WA 98087
(425) 742-9119 - phone
(425) 787-1055 - fax

To / From: (circle one)
_____
_____
(_____) _____-_____ phone (_____) _____-_____ fax

If we are requesting this authorization from you for our own use and disclosure, or to allow another health care provider or health plan to disclose information to us: we cannot condition our provision of services or treatment to you on the receipt of this signed authorization; you may inspect a copy of the protected health information to be used or disclosed; you may refuse to sign this authorization; and we must provide you with a copy of the signed authorization.

You have the right to revoke this authorization at any time, provided you do so in writing and except to the extent that the in formation has already been used/disclosed in reliance on this authorization. Unless revoked earlier or otherwise indicated, this authorization will expire 180 days from the date of signing or shall remain in effect for a period reasonably needed to complete the request.

I have reviewed and understand this authorization. I further understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

_____ _____/_____/_____
Signature of patient or representative (legal guardian, next of kin, POA) Date

Description of representative's authority: _____

DISCLOSURE TO THIRD PARTIES REQUIRING SPECIAL CONSENT

My signature below further specifically authorizes the release of healthcare information relating to the testing, diagnosis and/or treatment for (check the appropriate box(es)):

☐ HIV/AIDS virus ☐ Mental health/psychiatric disorders ☐ Reproductive health
☐ Sexually transmitted disease(s) ☐ Drug and/or alcohol abuse/treatment

_____ _____/_____/_____
Signature of patient or representative (legal guardian, next of kin, POA) Date

Description of representative's authority: _____

This document and the information in it do not constitute legal advice, and are not a substitute for legal or other professional advice. Users should consult legal counsel for advice regarding the application of the law and this document as it applies to the HIPAA regulations.