

INTERLAKE MEDICAL CENTER, PLLC

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Authorization for Interlake Medical Center, PLLC, to use or disclose my health care information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_

I. Authorization

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

- All health care information in my medical record
- Health care information in my medical records relating to the following treatment or condition: \_\_\_\_\_
- Health care information in my medical records for the date(s): \_\_\_\_\_
- Other (e.g., x-rays, bills), specify date(s): \_\_\_\_\_

Check if you DO NOT want to disclose the following health care information regarding testing, diagnosis, and treatment for (check all that apply):

- HIV (AIDS virus)
- Sexually transmitted diseases
- Psychiatric disorders/mental health
- Drug and/or alcohol use

II. You may disclose this health care information to:

- Name (or title) and organization: \_\_\_\_\_
- Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
- I will pick up the requested information myself, and I understand that I will be called when the requested information is ready.  
I can be reached at the following phone number: \_\_\_\_\_

III. Reason(s) for this authorization (check all that apply):

- At my request
- Check only if Interlake Medical Center, PLLC, requests the authorization for marketing purposes.
- Check only if Interlake Medical Center, PLLC, will be paid or get something of value for providing health information for marketing purposes.
- Other (specify): \_\_\_\_\_

IV. This authorization ends: (this document does not permit disclosure of health information created more than 90 days after the date it is signed)

- In 90 days from the date signed
- On (date): \_\_\_\_\_
- When the following event occurs: \_\_\_\_\_

V. 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.
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Interlake Medical Center, PLLC based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from Interlake Medical Center, PLLC.
- Write a letter to Interlake Medical Center, PLLC.

Once health care information is disclosed, the person or organization that receives it may re-disclose it, privacy laws may no longer protect it.

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name if signed on behalf of patient

\_\_\_\_\_  
Relationship