



AUTHORIZATION FOR Northwest Asthma and Allergy Center TO REQUEST OR DISCLOSE MY HEALTH CARE INFORMATION

Patient name \_\_\_\_\_ Date of birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Previous name (if any) \_\_\_\_\_

1. Information to be released (check all that apply):

- The most recent \_\_\_\_ years of pertinent information
All medical records
Specific health care information in my medical record
Other (e.g., X-rays, bills), specify date(s):

\*\*Please check any of the following health care information regarding testing, diagnosis, and treatment you wish to exclude:

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

I am requesting this health care information from:
Northwest Asthma & Allergy Center
Name (or title) and organization or class of persons:
Address
City State Zip
Phone #
FAX#

I wish to disclose this health care information to:
Northwest Asthma & Allergy Center
Name (or title) and organization or class of persons:
Address
City State Zip
Phone #
FAX#

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

- Self
Doctor
Attorney
Insurance
Other (specify)

This authorization ends:

- On (date):
When the following event occurs:
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).

3. 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. If I did, it would not affect any actions already taken by Northwest Asthma & Allergy Center based on 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 Northwest Asthma and Allergy Center, Inc. Or
Write a letter to Northwest Asthma and Allergy Center, Inc.

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

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Physicians Affiliated with the University of Washington School of Medicine, Children's Hospital and Medical Center and ASTHMA Inc.