

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name _____ Date of Birth _____
Last First MI mm/dd/yyyy

I Authorize WOODCREEK HEALTHCARE to

- Release Health Care Information To Obtain Health Care Information From Exchange Health Care Information With

Name _____
Name (Provider, Office, Hospital, School, Individual Entity, or Class of Persons)

Address _____ Phone _____
Street or P.O. Box
 _____ Fax _____
City State ZIP

The Following Communication or Records are Requested (Check all that apply)

- All health care information in my medical record Verbal, telephone, or email communication
- Health care information in my medical record relating to the following treatment, condition, or date(s) of treatment _____
- _____
- Other, please specify including date(s) _____

Protected Information - You may use or disclose health care information regarding testing, diagnosis, and treatment (Check all that apply)

- HIV/AIDS Sexually transmitted diseases
- Drug/alcohol abuse Psychiatric disorders/mental health

Reason(s) for this Authorization (Check all that apply)

- At my Request Assessment Continuity of Care Coordination of Care Other, specify _____

This Authorization Expires

- On this Date _____
mm/dd/yyyy On this Event, please specify _____
- 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes other than payment)

Patient Rights

I understand I do not have to sign this authorization in order to receive health care benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form to receive health care when the purpose is to create health care information for a third party. I also understand Woodcreek will in no way use this information for marketing purposes.

I may revoke this authorization in writing. If so, it would not affect any actions already taken by Woodcreek Healthcare 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 to fill out a revocation form, or submit a request in writing to Woodcreek Healthcare.

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

Release of Information of a Minor

To determine whether the minor child is required to sign this release, any of the following must be met:

- For mental health records - age 13
- For drug and alcohol abuse records - age 13
- For sexually transmitted diseases, including HIV records- age 14
- An emancipated minor (legally independent) or married to someone at or above age 18
- For birth control and pregnancy related care records - any age

Signature _____
Printed Name

Relationship to Patient _____
Date