

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you.

Failure to provide *all* information requested may invalidate this Authorization.

PATIENT NAME: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize **ARTISTIC PLASTIC SURGERY CENTER, PLLC**

to release to: **Chris Nichols, MD**
Pearl Plastic Surgery
6002 North Westgate Blvd., Suite 160
Tacoma, WA 98406
253-759-4522
Fax 253-759-4699

*****Please mail this form to Dr. Nichols at the address above or fax it to: 253-759-4699**

a. All health information pertaining to my medical history, mental or physical condition and treatment received - **OR**

Only the following records or types of health information (including any dates):

b. I specifically authorize release of the following information (check as appropriate):

Mental health treatment information. (A separate authorization is required to authorized the disclosure or use of psychotherapy notes.) ¹

HIV test results.

Alcohol/drug treatment information.

PURPOSE

Purpose of requested use or disclosure: Patient request; **OR** Other

EXPIRATION

This Authorization expires [insert date]: _____

MY RIGHTS

I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. ²

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing and submit to:

ARTISTIC PLASTIC SURGERY CENTER, PLLC
3515 South 15th Street, Suite 101
Tacoma, WA 98405

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

I have a right to receive a copy of this authorization.³

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by state law and may no longer be protected by federal confidentiality law (HIPAA).

If this box is checked, the Requestor will receive compensation for the use or disclosure of my information.⁴

SIGNATURE

Date: _____

Time: _____ am/pm

Signature: _____

(Circle one: patient / representative / spouse / financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient:

Witness: _____

¹ If mental health information covered by the Lanterman-Petris-Short Act is requested to be released to a third party by the patient, the Physician, licensed psychologist, social worker with a master's degree in social work or marriage and family therapist, who is in charge of the patient must approve the release. If the release is not approved, the reasons therefore should be documented. The patient could most likely legally obtain a copy of the record himself or herself and then provide the records to the third party, however.

² If any of the HIPAA recognized exceptions to this statement applies, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a healthy plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.

³ Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures.

⁴ The requestor is to complete this section of the form.