EASTSIDE ENDOSCOPY CENTER

Authorization to Use or Disclose Protected Health Information

Patient name: _____ Date of birth: _____

Previous name: _____

I. My Authorization

Eastside Endoscopy Center may use or disclose the following health care information (check all that apply):

□ All health care information in my medical record

□ Health care information in my medical record relating to the following treatment or condition:

_____

□ Health care information in my medical record for the date(s): _____

□ Other (e.g., X-rays, bills)—specify date(s): _____

Uses and Disclosures Requiring Specific Authorization

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

□ HIV/AIDS

□ Mental Health or Illness

□ Reproductive Care (minors only)

□ Sexually Transmitted Diseases

□ Drug and/or Alcohol Abuse

Minors – a minor patient's signature is required in order to disclose information related to reproductive care, sexually transmitted diseases (if age 14 and older), HIV/AIDS (if age 14 and older), drug and/or alcohol abuse (if age 13 and older), and mental health or illness (if age 13 and older).

You may disclose this health care information to:

Name (or title) and organization or class of persons: _____

Address (optional): _____ City: _____ State: ___ Zip: _____

Reason(s) for this authorization to use or disclose my health care information (check all that apply):

□ at my request

□ for marketing purposes

□ check here if **Eastside Endoscopy Center** will be paid for providing health care information for marketing purposes by the third party whose product or service is described in the marketing

□ other (specify) _____

This authorization ends:

□ on (date): _____ or 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)

II. My Rights

1. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits). However, I do have to sign an authorization form:
   - to receive research-related treatment in connection with research studies **or**
   - to receive health care when the purpose is to create health care information for a third party.
2. I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by **Eastside Endoscopy Center** in reliance on this authorization before it receives my written revocation. 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 **Eastside Endoscopy Center** or
   - Write a letter to **Eastside Endoscopy Center**.

III. Protection after Disclosure. I understand that once my health care information is disclosed, the person or organization that receives it may re-disclose it and that 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)

_____

Minor patient's signature, if applicable Date Time