BELLINGHAM
OB/GYN

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

I, _____, authorize _____

To use and/or disclose my health information to:

BELLINGHAM OB/GYN
3200 SQUALICUM PARKWAY
BELLINGHAM, WA 98225
PHONE (360) 671-4944
FAX (360) 738-4593

Patient's Name: _____ Date of Birth: _____

Previous/Maiden Name: _____

By initialing the spaces below, I specifically authorize the use and/or disclosure of the following health information and/or records:

____ Please send the entire record (all documents)
____ Clinician office chart notes
____ All medical records (including nursing records & progress reports)
____ Laboratory Reports
____ Transcribed records
____ Pathology Reports
____ Medical records needed for
____ Diagnostic imaging Reports Continuity of care
____ Billing Statements
____ Other:

The following items must be initialed to be included in the use or disclosure of other health information:
____HIV / AIDS related health information and/or records
____Mental health information and/or records
____Genetic testing information and/or records
____Drug/alcohol diagnosis, treatment and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information)

- Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to **BELLINGHAM OB/GYN**
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy and information to be used or disclosed under this authorization
- I also understand that, if the person or entity receiving this information is not a healthcare provider, or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.
- I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so
- Unless revoked earlier, this authorization will expire 180 days from the date of signing

_____ _____
Patient Signature Date