cares northwest

Protecting children, healing lives.

AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL INFORMATION

I authorize **(name of health care provider)** CARES Northwest to use and/or disclose the medical information identified below regarding **(name of individual)** _____

(date of birth) _____ to

_____ **(name of recipient)**

_____ **(agency)**

_____ **(address)**

_____ **(city, state & zip code)**

_____ **(phone number/fax number/email)**

For the purpose of: **(describe each purpose of use/disclosure)** _____

By ***initialing*** the spaces below, I specifically authorize the use and/or disclosure of the following medical information and/or medical records, if such information and/or records exist:

_____CARES Northwest reports

_____Other: _____

* The following items must be initialed to be included in the use and/or disclosure of other medical information:

_____*HIV - positive test results or HIV diagnosis

_____*Genetic testing information and/or records

_____*Drug/alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe: _____

_____*Mental health information and/or records

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV - positive test results or HIV diagnosis, specially protected mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

I understand that the person or entity I am authorizing to use and/or disclose the information may receive compensation for doing so.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain health care services or reimbursement for services unless authorization is required to bill my insurance company. The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing or on **(insert applicable date or event)** _____.

_____ _____

Signature of Parent/Legal Guardian or Patient | Date

_____ _____

Print Name of Parent/Legal Guardian or Patient | Relationship to Patient (if applicable)

(A copy of this signed form will be provided to the patient or patient's legal representative.) Auth to Use &-or Disclose Med Info HIPAA Form BLANK.doc, 7/31/20