www.longvieworthopaedic.com

625 9th Avenue, Suite 210
Longview, WA 98632-2465
Phone: 360-501-3400 | Fax: 360-423-6862

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name (please print):______________________________ Phone #:____________________

Previous Name(s): ______________________________ Date of Birth: ____________________

PLEASE OBTAIN INFORMATION FROM:

____
Name of Provider/Clinic/Organization

____
Street Address

____
City, State, Zip Code

Phone: ____________ Fax: __________

PLEASE SEND INFORMATION TO:

____
Name of Provider/Clinic/Organization

____
Street Address

____
City, State, Zip Code

Phone: ____________ Fax: __________

☐ **Pt. to Pick Up** ☐ **Mail** ☐ **Fax** ☐ **Portal (Electronic)** ☐ **Disk**

Longview Orthopedic Associates may use, obtain or disclose the following health care information. Charges may apply depending on quantity of request. (Check all that apply):

Information to be released - Re: (Body Part) ______________________________ **covering the periods of health care:**

Month/Year: ______________

☐ Clinic/Office Notes
☐ Operative Reports
☐ Physical Therapy Reports
☐ Outside Imaging Reports
☐ X-Ray/Images CD
☐ Itemized Billing Records
☐ MRI Reports
☐ Laboratory Test Results
☐ Complete Health Records

☐ Other (specify):____

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

☐ HIV (AIDS Virus)
☐ Psychiatric Disorders/Mental Health
☐ Drug and/or Alcohol Use
☐ Sexually Transmitted Diseases

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 Longview Orthopedic Associates 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):________________ ☐ 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).

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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 Longview Orthopedic Associates 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 Longview Orthopedic Associates or
   - Write a letter to Longview Orthopedic Associates.

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's signature

____
Date Time

____
Printed Name if signed on behalf of the patient

____
Relationship
(Parent, legal guardian, personal representative)