Authorization for Care Medical Group to Receive, Use or Disclose My Health Care Information

Patient name: _____ Date of birth: _____

Previous name: _____

I. My Authorization to: Care Medical Group, PeaceHealth St. Joseph Medical Center, and/or other Provider (s):

You may receive, 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): _____

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

☐ HIV (AIDS virus)
☐ Sexually transmitted diseases
☐ Psychiatric disorders/mental health
☐ Drug and/or alcohol use

You may disclose this health care information to:

☒ Name (or title) and organization: Care Medical Group, Inc.
Address: 4280 Meridian St Ste 120 City: Bellingham State: WA Zip: 98226

Reason(s) for this authorization (check all that apply):

☒ at my request
☐ other (specify): _____

This authorization ends:

☒ on (date): December 31, 2019
☐ in 90 days from the date signed
☐ when the following event occurs: _____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Care Medical Group, based upon this authorization. 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 care Medical Group. Or
- Write a letter Care Medical Group.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)