

**Authorization for: \_\_\_\_\_  
to Use or Disclose My Health Care Information**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name : \_\_\_\_\_

**I. My Authorization**

**You may use or disclose the following health care information (check all that apply):**

- All health care information in my medical record to include HIV (AIDS virus), Sexually transmitted diseases, Psychiatric disorders/mental health, drug and/or alcohol use.
- 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. labs, X-rays, bills), specify date(s): \_\_\_\_\_

**Specifically exclude the following:**

- HIV (AIDS virus)  Sexually transmitted diseases
- Psychiatric disorders/mental health  Drug and/or alcohol use
- Other \_\_\_\_\_

**You may disclose this health care information to:**

L. James Wagner, N.D.  
119 N. Commercial, Suite 315, Bellingham, WA 98225 tel. 360-647-1831

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

- At my request  Other:(specify)\_\_\_\_\_
- This authorization ends** (this document does not permit disclosure of health information created more than 90 days after the date it is signed.)
- In 90 days from the date signed  On (date):\_\_\_\_\_
- When the following event occurs:\_\_\_\_\_

(no longer than 90 days from date signed)

**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 3rd party.
- I may revoke this authorization in writing. If I did, it would not affect any actions already taken by [name of practice or health care facility] 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 the [practice/health care facility]. Or write a letter to the [practice/health care facility].
  - 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 Time

\_\_\_\_\_  
Printed name if signed on behalf of the patient  
Last Update:\_\_\_/\_\_\_/\_\_\_

\_\_\_\_\_  
Relationship (parent, legal guardian)