Faith Home Care Practitioners, PLLC
34 NE Boistfort St. Ste. 123
Chehalis, WA 98532
www.faithhcp.com

Authorization for use and Disclosure of Protected Health Information

Patient name_____D.O.B. _____

Authorization of release from:

Previous Medical Provider _____

Address_____

Phone_____ Fax_____

Authorization of release to:

Faith Home Care Practitioners
34 NE Boistfort St. Ste. 123
Chehalis, WA 98532

Phone: (360) 996 – 4443
Fax: (855) 619 – 1638

Patient Authorization:

You may use or disclose of the following healthcare information (check all that apply)

_____Last 2 years of Medical Records

_____My healthcare information for the date(s) _____

_____Other_____

Please Initial: _____HIV (AIDS virus) _____Sexually transmitted diseases

_____Psychiatric disorders/mental health _____Drug and/or alcohol use

_____Date(s) _____

Purpose for which disclosure is being made (check one of the following)

_____Doctor_____Transferring Care_____Personal_____Attorney_____Insurance

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 healthcare when the purpose is to create health care information for a third party. I may revoke this authorization in writing. To view the process for revoking this authorization, please read the **Privacy Notice** to patients posted at the facility where your information is being released. I understand that once health care information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclosed it at which time I may no longer be protected under **Privacy Laws.**

SIGNATURE_____DATE _____

Relationship to patient:_____Parent_____Legal Guardian_____Power of attorney for health care_____Other _____

Attach legal document if you are the legal guardian or Power of Attorney for Health care.

Expires 90 days from the date signed.