PROLIANCE ORTHOPAEDICS & SPORTS MEDICINE
BELLEVUE • ISSAQUAH • REDMOND

A service of PROLIANCE SURGEONS®

Authorization for Proliance Surgeons, Inc., P.S. to Use or Disclose My Health Care Information

Patient name: _____ Date of birth: _____

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

☐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 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: _____

_____

Address: _____ City: _____ State: _____ Zip: _____

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

☐at my request

☐other (specify): _____

☐check only If practice request the authorization for marketing purposes

☐check only if practice will be paid or get something of value for providing health information for marketing purposes

☐**This authorization ends:** *(If disclosure is to a financial institution or employer of the patient for purposes other than payment, then as to those disclosures this authorization expires 90 days after signed, unless renewed.)*

☐on (date): _____

☐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 for:

- To take part in 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 Proliance Surgeons, Inc., P.S. 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. Or
- Write a letter to the practice.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws my 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)

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