WALK-IN HEALTH CLINIC
INCORPORATED

Authorization to Use or Disclose Protected Health 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
- ☐ 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, must be checked in order for us to disclose this information):

- ☐ 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 or class of persons: _____

Address (optional): _____ City: _____ State: ___ Zip: _____

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

- ☐ at my request
- ☐ 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)

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. If I did, it would not affect any actions already taken by The Walk-In Health Clinic 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 Walk-In Health Clinic, **or**
- Write a letter to The Walk-In Health Clinic.

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 Relationship (parent, legal guardian, personal representative)