Tri-City Radiology, Inc. P.S.
Authorization to Use or Disclose Protected Health Information

Patient name: _____ Date of birth: _____

Previous name: _____

To: _____

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
- ☐ Mental Health or Illness
- ☐ Sexually Transmitted Diseases
- ☐ Drug and/or Alcohol Abuse

You may disclose this health care information to: **Tri-City Radiology, Inc. P.S.**
7221 W. Deschutes Ave. Suite A
Kennewick, WA. 99336
Phone: 509-374-4030 Fax: 509-374-8690

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

1. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits). However, I do have to sign an authorization form:
   - to receive research-related treatment in connection with research studies **or**
   - to receive health care when the purpose is to create health care information for a third party.
2. I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by Tri-City Radiology in reliance on this authorization before it receives my written revocation. 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 Tri-City Radiology or
   - Write a letter to Tri-City Radiology.

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)