Pacific Center for Neurostimulation

10740 Meridian Avenue N, Suite 205, Seattle, Washington 98133
phone 206.535.6292 | fax 206.356.1151

Authorization to Use or Disclose Protected Health Information

Patient name: _____ Date of birth: _____
Previous name/s: _____

I. My Authorization

Pacific Center for Neurostimulation PLLC 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):
  _____

Uses and Disclosures Requiring Specific Authorization:

Pacific Center for Neurostimulation PLLC may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

- □ HIV/AIDS
- □ Mental Health or Illness
- □ Reproductive Care (minors only)
- □ Sexually Transmitted Diseases
- □ Drug and/or Alcohol Abuse

Minors – a minor patient's signature is required in order to disclose information related to reproductive care, sexually transmitted diseases (if age 14 and older), HIV/AIDS (if age 14 and older), drug and/or alcohol abuse (if age 13 and older), and mental health or illness (if age 13 and older).

You may disclose the above health care information to:

Name (or title) and organization or class of persons:
_____

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

Reason(s) for this authorization to use or disclose my health care information (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

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 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 Pacific Center for Neurostimulation PLLC 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 Pacific Center for Neurostimulation PLLC

   or
   - Write a letter to Pacific Center for Neurostimulation PLLC at 10740 Meridian Avenue N., Suite 205 Seattle, WA 98133.

III. Protection after Disclosure. I understand that once my health care information is disclosed, the person or organization that receives it may re-disclose it and that 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)

_____

Minor patient's signature, if applicable Date Time