

Authorization to Disclose Health Information to The Pujari Center

Patient Name: _____ Health Record Number: _____

Date of Birth: _____ S.S. No.: _____

1. I authorize the use or disclosure of the above named individual's health information as described below:

2. The following individual or organization is authorized to make the disclosure:

Address _____

3. The type and amount of information to be used or disclosed is as follows:
(include dates where appropriate)

- problem list
- medication list
- list of allergies
- immunization record
- most recent history and physical
- most recent hospital discharge summary
- laboratory results from (date) _____ to (date) _____
- x-ray and imaging reports from (date) _____ to (date) _____
- consultation reports from (doctor's names) _____

- entire record
- other _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to:

The Pujari Center
1370 Stewart Street
Seattle, WA 98111
206.344.8053
888.882.8053

For the purpose of the provision of health services.

6. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire at the end of the pending of my claim or lawsuit.
7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
8. You are further authorized to discuss my case in detail with The Pujari Center or their representatives, and assist them in any way they may request your services.
9. I acknowledge receipt of a signed copy of this authorization _____ (Initials)

Signature of Patient or Legal Representative

Date

If Signed by Legal Representative, Signature of Witness

Relationship to Patient: _____

***A photocopy of this Authorization will be considered as an original.
This Release complies with the HIPAA Privacy Rules***