Longview Orthopedic Associates, PLLC
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Longview, WA 98632-2465

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www.longviewpsi.com/loa

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name (please print):_____Phone #:_____

Previous Name(s): _____ Date of Birth: _____

PLEASE OBTAIN INFORMATION FROM:

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City, State, Zip Code

Phone: _____ Fax: _____

PLEASE SEND INFORMATION TO:

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City, State, Zip Code

Phone: _____ Fax: _____

Pt. to **Pick Up** or **Mail**
(Circle one if applicable)

Information to be released – Re: _____ covering the periods of health care: Month/Year: _____
(Body Part)

(Check all that apply)

[] Clinic/Office Notes [] Outside Imaging Reports [] MRI Reports
[] Operative Reports [] X-ray/Images CD [] Laboratory Test Results
[] Physical Therapy Reports [] Itemized Billing Records [] Complete Health Records
[] Other, (specify) _____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply)

[] HIV (AIDS virus) [] Psychiatric disorders/mental health [] Drug and/or alcohol use
[] Sexually transmitted diseases

My Rights

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). If I revoke this authorization, it will not affect any actions already taken by Longview Orthopedic Associates based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. This authorization will expire in 90 days from date of signature. Two ways to revoke this authorization are by:

- Filling out a revocation form (available from Longview Orthopedic Associates).
- Writing a letter to Longview Orthopedic Associates.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. A copying fee may apply.

_____ _____
Patient or legally authorized individual's signature Date Time

_____ _____
Printed Name if signed on behalf of the patient Relationship
(parent, legal guardian, personal representative)

Updated 7/09