HIPAA
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name _____
List all names used

Date of Birth _____ **Social Security Number** _____

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

Information to be released from: _____
Name of designated Facility or Provider

_____
Address, City, State, Zip

Information to be sent to: **Lexitas**
307 29th St NE, Ste 101
Puyallup, WA 98372-6718
Phone: 253-445-3400 § Fax: 253-445-4425
warecords@lexitaslegal.com

Information to be disclosed:

- ☐ Entire Medical Record
- ☐ Entire Medical Record from _____ *Date* **To** _____ *Date*
- ☐ All Itemized Billing Statements & CPT Codes
- ☐ All Itemized Billing Statements & CPT Codes from _____ *Date* **To** _____ *Date*
- ☐ All Films/X-rays/MRIs
- ☐ All Films/X-rays/MRIs relating to _____
- ☐ Other _____

Purpose for which disclosure is being made: *(Please check one of the following)*

☐ Attorney ☐ Insurance ☐ Doctor ☐ Personal

Patient Authorization:
I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. **Exclude** the following information from the records released; (Please initial)

_____ Drug/Alcohol abuse/treatment & diagnosis

_____ Sexually Transmitted Disease (STDs)

_____ HIV/AIDS diagnosis/treatment/testing

_____ Mental Illness or psychiatric diagnosis/treatment

My Rights:
I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it at which time it may no longer be protected under Privacy laws.

Signature: _____ Date: _____
(Patient, Guardian, or Authorized Representative)

This authorization will expire 90 days from the date signed
A copy of this authorization shall have the same force and effect as the original