AUTHORIZATION TO USE OR DISCLOSE MY HEALTH CARE INFORMATION

Patient name:______________________________ Date of birth:____/____/________
Previous name:____
I give my authorization for: (doctor, clinic) ____
Address/phone____
____

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 following date(s):____________________
( ) Other (ie: 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 virus)
( ) Psychiatric disorders/mental health
( ) Sexually transmitted diseases
( ) Drug and/or alcohol use

You may disclose this health care information to:

Martina Koller, MD
9730 3[Rd] NE Suite 208
Seattle, WA 98115
P) 206-522-5646 x 1021
F) 206-902-2006

Reason(s) for this authorization (check all that apply) ( ) at my request ( ) other (specify)
This authorization ends: ( ) in 90 days from the date signed
( ) on (date)__/__/____
( ) when the following event occurs________________________
(no longer than 90 days from date signed)

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). However, I do have to sign the authorization form:
*To take part in a research study or
*To receive health care when the purpose is to create health care information for a third party.
I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Martina Koller, MD based upon this authorization. I may not be able to revoke this authorization if it's purpose was to obtain insurance. Two ways to revoke this authorization are:
*Fill out a revocation form. A form is available from Dr. Koller
*Write a letter to Dr. Koller

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, etc.)