

**Authorization to Disclose My Health Care Information**

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Previous name: \_\_\_\_\_ SSN: \_\_\_\_\_

**I. My Authorization**

I authorize: Robert Olson, MD., F.A.C.O.G  
2950 Newmarket St. #101-261  
fax: 360-398-7153

To disclose this health care information to:

\_\_\_\_\_  
(Clinic or Physician Name) (Phone Number)  
\_\_\_\_\_  
(Address) (City) (State/Zip)

**You may disclose the following health care information (check all that apply):**

- The last two years of all health care information in my medical record
- 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): \_\_\_\_\_

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

- HIV (AIDS virus)
- Sexually transmitted diseases
- Psychiatric disorders/mental health
- Drug and/or alcohol abuse

**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 healthcare benefits (treatment, payment or enrollment). 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. I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Robert Olson, M.D. based upon this authorization, 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 available from this practice. Or
- Write a letter to Robert Olson M.D.

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