Summit Neurology

OUTGOING REQUEST
FOR PROTECTED HEALTH INFORMATION (PHI)

AUTHORIZES SUMMIT NEUROLOGY TO RELEASE INFORMATION TO THE FACILITY/PERSON YOU LIST BELOW (see instructions at end of form for submission)

Patient Name_____ Date of Birth _____

Previous name _____

AUTHORIZED INFORMATION

I authorize:

Summit Neurology *(including all clinics, offices and ancillary services)*
2075 Barkley Boulevard, Suite 222 *Bellingham, WA 98226*

To disclose health care information to:

Facility/clinic: _____

Provider/person: _____

Address: _____

Phone: _____ Fax: _____

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

☐ All health care information in my medical record *(see next section to release protected information)*

☐ Health care information in my medical record relating only to the following treatment or condition: _____

☐ Health care information in my medical record only for the date(s) of: _____

- ☐ Laboratory/X-Rays/Imaging: _____
- ☐ Billing/Payment: _____

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

- ☐ HIV (AIDS virus)
- ☐ Sexually transmitted diseases
- ☐ Mental health or illness
- ☐ Drug and/or alcohol use
- ☐ Reproductive health care – **only for minors under 18 years of age**

Minors – a minor patient's signature is required in order to disclose information related to reproductive care (*at any age)*, sexually transmitted diseases *(age 14 and older)*, HIV/AIDS *(age 14 and older)*, drug and/or alcohol abuse *(age 13 and older)*, and mental health or illness *(age 13 and older)*.

Patient Name _____ Date of Birth _____

AUTHORIZATION TERMS

Reason(s) for this authorization (check all that apply):

- ☐ At my request
- ☐ Transfer of care
- ☐ Other (specify):_____
- ☐ For marketing purposes

This authorization ends:

- ☐ On a specific date: _____
- ☐ When the following event occurs: _____
- ☐ 90 days from the date signed
- ☐ When I cancel this authorization

My Rights

A. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits). However, I do have to sign an authorization form:
   - to receive research-related treatment in connection with research studies or
   - to receive health care when the purpose is to create health care information for a third party.

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B. I may cancel this authorization in writing at any time. If I do, it will not affect any actions taken by Summit Neurology in reliance on this authorization before it receives my written cancellation. I may not be able to cancel this authorization if its purpose was to obtain insurance. To cancel this authorization:
   - complete the box below
   - write a letter to Summit Neurology

Protection after Disclosure

Information used or disclosed based on this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law.

Patient or legally authorized individual signature Date Time

Printed name (if signed on behalf of the patient) Relationship (parent, legal guardian, etc.)

Minor patient's signature, if applicable Date Time

☐ **CANCEL THIS AUTHORIZATION**

Patient signature: _____

Date and time: _____

Instructions for submitting this form:

1. You may submit a signed copy in person to the office.
2. You may mail it to:

   Summit Neurology
   2075 Barkley Boulevard, Suite 222
   Bellingham, WA 98226

3. You may fax it to: (360) 359-7194
4. You may request that a form be partially filled for you and sent via HIPAA compliant electronic signature service for your authentication and signature.