HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

1. **This authorization is voluntary. I understand that Sound Physicians will not base treatment, payment, enrollment, or eligibility for benefits on my signing this document.**

Patient's Full Name	**Patient's Date of Birth**
Address	**City, State Zip Code**
Patient's Telephone Number	**Email Address**

I hereby authorize use or disclosure of protected health information about me as described below.

2. ☐ **Myself: I request Sound Physicians to release my protected health information to Myself to the address listed above.**

   Select delivery method: ☐ **US Mail** ☐ **Electronic (email)**

3. ☐ **Other: I am the parent, or legally authorized representative of the patient listed above and request Sound Physicians to release my protected health information (or the patient information listed above) to:**

   Individual/Person: _____ **Company/Organization:** _____

   Street Address: _____

   City/State/Zip: _____ **Telephone #:** _____

   Select Delivery Method: ☐ **Fax number (only health providers / urgent):** _____

   ☐ **US Mail** ☐ **Email** _____

4. **Purpose of release/disclosure to other person/organization:**

   Reason For Disclosure:

   ☐ **Continuity of care/transfer of care**
   ☐ **Attorney/legal**
   ☐ **Insurance Company**
   ☐ **Workman's Compensation**
   ☐ **Patient Directive**
   ☐ **Other (specify)**

5. **The specific information that should be disclosed is (please give dates of service if possible):**

_____

_____

_____

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL ABUSE/SUBSTANCE USE DISORDER, HIV/AIDS, REPODUCTIVE HEALTH ISSUES, OR MENTAL HEALTH WILL BE DISCLOSED:

YES, DISCLOSE THIS INFORMATION * _____

NO, **DO NOT** DISCLOSE THIS INFORMATION * _____

6. **I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.**
7. **I may revoke this authorization at any time. Revocations (cancellations) must be made in writing and send the Sound Physicians Compliance Department as the address listed on this form. Revocations will not apply to information that already has been released.**
8. **This authorization expires on _____ (specify expiration date or event). If the expiration date is left blank, the authorization expires 60 days from the signature date.**

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

_____ _____

Signature of Patient **Date of Signature**

OR

_____ _____ _____

Signature of Guardian or Legally Authorized Representative (if patient is a minor or unable to sign) **Date of Signature** **Description of Authority to Act for the Individual**

_____

Printed Name of Legally Authorized Representative

Authorizations signed by a representative must contain a copy of the guardianship papers or power of attorney.

You may contact our Privacy Officer at the following address and phone number:

Compliance Department
Sound Physicians
1498 Pacific Avenue, Suite 500
Tacoma, WA 98402
1-855-768-6363
compliance@soundphysicians.com