Proliance
Pacific Rim Orthopaedic Surgeons

PATIENT: if you want PROS to send your records to another provider, use this form.

(For Outgoing PROS Records)
AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient: _____

Date of Birth: _____ Phone#: _____

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this Authorization.
I understand that I have a right to receive a copy of this Authorization.

Requesting Records from:	Where to send the records to:
Proliance Pacific Rim Orthopaedic Surgeons	Name/Facility: _____
Attention: Medical Records	Attention: _____
2979 Squalicum Parkway, Suite 203	Address: _____
Bellingham , WA, 98225	City: _____ State: _____ Zip: _____
Phone: (360) 733-7670 Fax: (360) 647-1901	Phone: ( ) _____ FAX: ( ) _____

Please send records from the following date range: from: to:

- ☐ Labs
- ☐ History and Physical
- ☐ Office/Progress Notes
- ☐ Other:

Purpose of requested use or disclosure:

- ☐ Continuing Care
- ☐ Patient Request
- ☐ Insurance
- ☐ Legal
- ☐ Other

I specifically authorize release of the following information (check and initial as appropriate):

- ☐ Mental health treatment information — Initial if requesting:
- ☐ HIV test results — Initial if requesting:
- ☐ Alcohol/drug treatment information — Initial if requesting:

*If not checked and initialed, the records containing such information can NOT be released.

Duration: This Authorization expires [insert date]: _____
*If no Date is given; this authorization will expire 6 months from the signature date.

Revocation: I may revoke this authorization at any time, but I must do so in writing and submit it to PROS. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

Re-disclosure: Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by Washington law and may no longer be protected by federal confidentiality law (HIPAA).

Conditioning: I may refuse to sign this Authorization. If I refuse to sign this Authorization, I should know that by law, my health information cannot be released. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

This authorization is being requested of you to comply with the terms of the Confidentiality of the Medical Information Act of 1981, Civil Code Section 56 et seq. and the Health Insurance Portability and Accountability Act (HIPAA) of 2003.

Patient Signature: _____ Date: _____

Legal Representative Signature: _____ Relationship to Patient: _____