GENESIS
REGENERATIVE MEDICINE

AUTHORIZATION TO DISCLOSE MY HEALTH CARE INFORMATION

Patient Name: _____ Date of Birth: _____

Previous Name(s): _____

I. MY AUTHORIZATION

You may 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 date(s): _____
- ☐ Other (e.g., 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)
- ☐ Sexually transmitted diseases
- ☐ Psychiatric disorders/mental health
- ☐ Drug and/or alcohol use

You may disclose this health care information to:

GENESIS REGENERATIVE MEDICINE
350 SOUTH 333RD STREET
FEDERAL WAY, WA 98003

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

- ☐ At my request
- ☐ Other (specify): _____

This authorization ends:

- ☐ In 1 year from the date signed
- ☐ On (date): _____
- ☐ When the following event occurs: _____

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 an 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 the Pain Center of Western Washington based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization I can fill out a revocation form, available from the Pain Center of Western WA, or I may write a letter to the Pain Center of Western WA.

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

_____ _____

Printed name if signed on behalf of the patient — Relationship
(parent, legal guardian, personal representative)