Martin Ross, M.D.
Tara Brooke, N.D.
The Healing Arts Partnership
511 2nd Ave W, Seattle, WA 98119
PH: 800-470-7217 FAX: 206-932-3738

Authorization to Use or Disclose My Health Care Information

Patient Name: _____ Date of Birth _____

Previous Names: _____

1. I authorize Dr. Martin Ross, M.D. or Dr. Tara Brooke, N.D.:

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

__ All health care information in my medical record including section 1A.

__ 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) _____

1A. 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 and mental health disorders
__ Drug and/or alcohol use

Reasons for this authorization (check all that apply):

__ At my request

__ Other (specify) _____

__ This authorization ends (Date) _____ (this document does not permit disclosure of health information created more than 90 days after the date it is signed)

__ When the following event occurs _____

__ So that I may receive copies of my health care records while in care at this clinic.

2. 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 and 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 Martin Ross, M.D. or Tara Brooke, N.D. and The Healing Arts Partnership based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. If you wish to revoke this authorization, please send your written request to the address above and the appropriate provider. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

You May disclose this information to: _____

_____

_____

Patient or legally authorized Individual signature *Date*

_____

Print name if signed on behalf of the patient *Relationship*