YAKIMA
Neighborhood Health

Yakima Neighborhood Health Services
12 South 8th St, Yakima WA 98901- 3020
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www.ynhs.org

Authorization for Yakima Neighborhood Health Services to Use or Disclose My Health Care Information

Patient Name: ______________________________________ Date of Birth: __________ Medical Record #______________
Previous Name(s): ___________________________________ Patient's Provider: _____________________________________

Information to be disclosed (written/verbal}(check all that apply)

☐ **All medical records in the last year**
☐ Last 3 years of office notes, consults, labs, and imaging
☐ Other ____
☐ All medical records (including records from other providers)
☐ Medical records relating to the following treatment or condition: ___________________________________

PLEASE READ CAREFULLY:
I **understand that my express consent is required for you to release information relating to *sexually transmitted disease, HIV, drug & alcohol use, psychiatric disorder. Information to not include records by other providers.* Please initial yes or no for release of the following:**

Yes	No		Yes	No	
		Sexually Transmitted diseases			**Psychiatric disorders/mental health**
		HIV (AIDS virus)			**Drug &/or Alcohol use**

You may disclose this health care information:
FROM: __________________________ TO: __________________________
__________________________ __________________________
__________________________ __________________________
__________________________ __________________________
(Provider name, organization, or group) (Provider name, organization, or group)

- **Reason(s) for this authorization (circle)**
  My request Transfer of care School Work Continuity of care Other ________________________________
- This authorization **ends 1 year from today,** or on the following, **whichever is earlier:** (check one)
  On (date): _______________________________________
  D 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 receive health care when the purpose is to create health care information for a third party.
- To take part in a research study.
- I may revoke this authorization in writing. If did, it would not affect any actions already taken by YNHS based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are: (1) Fill out an YNHS Revocation Form.; (2) Write a letter to YNHS, to the attention of Health Care Information Department or the Privacy Officer. 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 of patient or legally authorized individual