

The Ida Karlin Healing Center for Youth

Ovidio Peñalver, MD

Michelle Ost, MD ♦ Sylvia Morales-Bronner, MD ♦ Jennifer Sonney, ARNP ♦ Megan Spangler,
ARNP

319 5th St. SW Puyallup, WA 98371
phone 253.848.0351 ♦ fax 253.841.1397 ♦ www.idakarlincenter.com

Authorization for Use and Disclosure of Protected Health Information

I hereby authorize:

Name *Address* *Fax*

The Ida Karlin Healing Center for Youth
319 5th St. SW Puyallup, WA 98371

to use and/or disclose my protected health information, for the purpose(s) of:

Diagnosis and treatment
 Other: _____

to:

The Ida Karlin Healing Center for Youth
319 5th St. SW Puyallup, WA 98371
 Other: _____
Name *Address* *Fax*

I understand that:

- 1) This authorization is voluntary and I may refuse to sign this authorization without affecting my health care or the payment for my health care.
- 2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
- 3) I may revoke this authorization at any time by notifying **The Ida Karlin Healing Center** in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
- 4) If the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, the released information may no longer be protected by federal privacy regulations.

Type of Information to be Disclosed:

Entire Medical Record
 Courtesy Pages (*for personal use*)
 Other: _____

Expiration:

This authorization will expire 180 days from the date of signing, or: _____/_____/_____

Patient Name: _____

Printed Name of Patient's Representative

Patient Date of Birth: _____/_____/_____

Signature of Patient or Legal Representative

Relationship to Patient (*if applicable*):

- Parent or guardian of emancipated minor
 Court-appointed guardian

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- Executor or administrator of dependent's estate
- Power of Attorney