MT RAINIER CLINIC
Reach New Heights in Good Health Naturally

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS

Name of Patient: _____ Date of Birth: _____

I hereby authorize medical providers and personnel of MRC to discuss my protected health information with:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

I understand that certain information cannot be released without specific authorization as required by state or federal law. By initialing the lines below, I authorize the release of the following protected or sensitive information:

- Information regarding the patient's diagnosis and treatment for HIV/AIDS
- Psychotherapy notes from a Psychiatrist or Psychotherapist
- Treatment for alcohol or drug abuse reports

This authorization shall be in force and in effect from until at which time this authorization to use or disclose this protected health information expires.

Unless specified above, this authorization will expire 365 days from the date of signing.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that such revocation is not effective to the extent that the Clinic has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization.

_____ _____
Signature of Patient or Personal Representative Printed Name ❑ Self
❑ Other: _____

Date: _____

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