David W. Newell, MD

AUTHORIZATION TO USE, DISCLOSE, & RELEASE PROTECTED HEALTH INFORMATION

I understand the following:

- I have the right to refuse to sign this form for authorization to disclose or release my protected health information. Refusal to sign the authorization will not adversely affect my ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign this authorization may affect my ability to receive health care services is if the health care services are research-related or solely for the purpose of providing health information to someone else and the authorization is needed to make that disclosure.
- There may be a fee associated with this request.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.
- I have the right to receive a copy of this signed authorization.
- I may revoke this authorization in writing at any time. If I revoke this authorization, the information described below may no longer be used or disclosed for the purposes described in the written authorization. The only exception is when Seattle Neuroscience Institute has taken action in reliance on the authorization or the authorization was obtained as a condition of insurance coverage.

To revoke this authorization, send a written statement that you are revoking this authorization along with a copy of this authorization to:

Seattle Neuroscience Institute
550 17th Ave Suite 240
Seattle WA 98112

Seattle Neuroscience Institute does not print or release patient social security numbers unless required for billing. However, social security numbers may be included in patient information that is more than a few years old. The information you are authorizing to be released may include your social security number.

The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

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I authorize Seattle Neuroscience Institute to use and disclose a copy of the specific health information described below regarding:

Patient's Name: _____ DOB: _____
Phone: _____
Patient's Address: _____ City: _____ State: ___ Zip: _____

To be disclosed to: (Name of Recipient(s)): _____
Recipient(s) Address: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

I am requesting information from the following facility(s):

Hospital Name (List) & Phone Number	Clinic Name (List) & Phone Number

For the range of dates from: _____ to: _____
For the information related to the following diagnosis or injury:
_____
_____

Information to be disclosed:

- ☐ History & Physical
- ☐ Progress Notes
- ☐ Other (specify): _____

For the purpose of: _____
Unless revoked, this authorization expires in 180 days or on this Date: _____

_____ _____ _____
Signature (Patient or Legal Representative) Print Name DATE

_____
Relationship (if other than patient)

Terms: This authorization, unless expressly limited by me in writing, will extend to all aspects of testing and/or treatment of sexually transmitted diseases, AIDS, HIV Infection, alcohol and/or drug abuse, mental health conditions or other sensitive information.