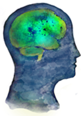

John R Holttum, MD
Holttum Psychiatric PLLC
324 West Bay Drive, Suite 214
Olympia, WA 98502

AUTHORIZATION TO OBTAIN, USE AND DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT NAME:____
Last First Middle

Home address:____

Home telephone:__________________________________ Date of Birth: ____

I authorize John Holttum, MD and the named party below, to exchange written and verbal information including my protected health information, including medical treatment, mental health treatment, educational information for the purpose of providing psychiatric assessment, diagnosis, treatment or coordinating care unless specified otherwise below.

Name/Facility:____

Address:____City:_______________________________

State:_________ZIP:_________________________Phone:____Fax:__________________________________

INFORMATION COVERED UNDER THIS RELEASE

____ Entire medical record (Examples include discharge summaries, medical assessments, lab data and information from a primary care physicians office)

____ Ongoing communication regarding psychiatric or mental health care (Examples include ongoing care with a primary care physician or mental health provider)

____ Individual Education Plan, school psychological testing, and information relating to the academic performance and behavior of child in a school setting.

____ Psychological testing

____ Information for referral purposes

____ Other (please specify)____

____ Specific authorization for information related to testing, diagnosis and treatment for drug or alcohol use.

____ Specific authorization for information related to testing, diagnosis and treatment of sexually transmitted diseases or HIV

The purpose of this disclosure is: Medical care__________ Legal Matter___________ Insurance_____________ Personal:____________

TERM: Unless otherwise specified this authorization will expire on termination of treatment with Dr Holttum or if for a minor, the time at which the minor reaches age 13.

This authorization expires:

_____ Termination of treatment with Dr Holttum or if a minor reaches age 13. (Default)
____ 90 days from the date signed
____ on other date, reason or event (specify) ____

By my signature below, I hereby authorize John Holttum MD to obtain, use and/or disclose my health information for the term of this Authorization for the specific purposes listed ("At the request of the patient" is sufficient if the patient is initiating this Authorization).
I understand that once John Holttum MD discloses my health information to the recipient, John Holttum cannot guarantee that the recipient will not redisclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of Dr Holttum's treatment of me; except, however, if my treatment by Dr Holttum is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Dr Holttum may refuse to treat me if I do not sign this Authorization. I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to John Holttum. the revocation will be effective immediately upon John Holttum's receipt of my written notice, except that the revocation will not have any effect on any action taken by John Holttum in reliance on this Authorization before it received my written notice of revocation

I have read and understand the terms of this authorization and have had an opportunity to ask questions about obtaining, using and disclosing my health information. By my signature below, I hereby, knowingly and voluntarily authorize John Holttum to obtain use and/or disclose my health information in the manner described above.

X____X____X______________________________
Signature of Patient or Personal Representative Relation to patient (self, guardian, parent etc) Date