Term: I understand that this Authorization will remain in effect:

- ☐ One year from the date of these authorizations.
- ☐ Until the Provider fulfills this request.
- ☐ Until the following event occurs:

  ____

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The 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.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at HCC. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the HCC at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Questions: I may contact the HCC, 9507 North Division Street, Spokane, WA 99218. Phone (509) 466-6632.

____ ________________

Signature Date

____ ________________

Signature (age 13 to 17) Date