

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This Authorization must be signed by the patient. If the patient is under 18 years of age, legally incompetent, or physically unable to sign, the parent or legal guardian must provide authorization.

Patient Name: _____ Date of Birth: _____
 Address: _____ Soc. Sec. Number: _____
 City: _____ Phone Number: _____
 State: _____ Zip: _____ E-mail: _____

I HERE BY AUTHORIZE WASHINGTON HEALTH SYSTEM TO:

Obtain Records From:	
Name:	_____
Address:	_____
Phone:	_____

Release Records To:	
Name:	_____
Address:	_____
Phone:	_____

FORMAT OF RECORD: A PAPER COPY or ELECTRONICALLY (not MAC compatible)

INFORMATION TO BE RELEASED/OBTAINED:

- All of the Below
 Consultation Reports
 Lab Data
 Last 3 Years of Progress Notes
 Problem List
 Immunization Record
 Cardiology Data
 Last Documented Mammogram, Pap, Colonoscopy
 Medication List
 Radiology Data
 Allergy List
 Other: _____

DATES OF SERVICE REQUESTED: From: _____ to _____

THIS INFORMATION WILL BE USED FOR THE FOLLOWING PURPOSE: _____

HIV and Mental Health information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated.

DO NOT RELEASE: _____
 Drug/Alcohol
 HIV/AIDS
 Mental Health

This authorization automatically expires 6 months from the date of the patient's or personal representative's signature.

- I understand that there may be information in my health record information relating to sexually transmitted disease, AIDS, or HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- I may revoke this authorization at any time by submitting a *written* notice of revocation to the records department to the WHS Physician Practices Records Management office. I understand that notice cannot be revoked if records have already been released.
- I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure by the recipient and the information may not be protected by federal confidentiality rules.
- I may refuse to sign this authorization. My refusal will not affect my treatment or payment for my care. The WHS Physician Practices Records Management department may receive compensation for the use or disclosure of this information.
- In the case of a minor child: I certify that no Court Order is currently in force that would prohibit my access to these records or prohibit my power to consent upon another person.
- In the case of a deceased patient: I, the undersigned next of kin, certify that I assumed responsibility for the disposition of the body of the deceased. There has been no probate of the decedent's Estate and there is no intent to enter the Estates into probate.

 Patient or Personal Representative Signature

 Date / Time

 Print Name of Patient or Personal Representative

 Relationship to Patient (if applicable)