

Center for Women's Health at Evergreen

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Authorization for the Disclosure of My Health Care Information

(This form must be completed in its entirety in order to be processed)

Patient Name: (Print) _____ **Date of Birth:** ____ / ____ / ____

Phone #: _____ **Previous Name:** (if applicable) _____

Information to be released by:

Name: _____

Organization: _____

Address: _____

Phone #: _____

FAX: _____

Information to be released to:

Name: _____

Organization: _____

Address: _____

Phone #: _____

FAX: _____

MY AUTHORIZATION:

NEED RECORDS BY: _____

TYPE OF INFORMATION TO DISCLOSE: (Check appropriate box)

Most recent 2-year history

Other _____ (please specify)

CWH will provide one courtesy copy of each patient's entire medical chart. Each additional copy will be subject to WA state medical copying fees.

****Please **DO NOT INCLUDE** the following health care information from my records:****

HIV / AIDS virus

Sexually Transmitted Diseases (STD)

Psychiatric disorders / mental health

Drug and/or alcohol use

(If I choose to exclude this information, I understand it will take longer to process my request for records)

REASON(S) FOR THIS AUTHORIZATION: (check all that apply)

At my request

Transferring Care

Other (specify): _____

THIS AUTHORIZATION ENDS: After this date occurs: _____ **OR** 90 days from the date signed below: _____

MY RIGHTS:

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).

However, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health care information for a third-party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by the Center for Women's Health at Evergreen based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Two ways to revoke this authorization are fill out a revocation form (a form is available from the Center for Women's Health at Evergreen) or to write a letter to the Center for Women's Health at Evergreen.

Once health care information is disclosed, the person/organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature

Date

Print your name if signed on behalf of the patient

Relationship (parent, legal guardian, personal representative)

PROVIDER COMMENTS: _____

PLEASE ALLOW 15 BUSINESS DAYS FOR PROCESSING

Last update: 6/8/11