

AUTHORIZATION FOR THE DISCLOSURE OF MY HEALTH CARE INFORMATION *page 1*

Patient Name: (Print) _____ Date of Birth: _____
Previous Name: _____ S.S. Number: _____ - _____ - _____
Phone #: _____

Information to be released by: Information to be released to:
Name: _____ Name: _____
Organization: _____ Organization: _____
Address: _____ Address: _____

Phone # _____ Phone # _____
(All records will be mailed to the address designated unless otherwise specified)

MY AUTHORIZATION:

TYPE OF INFORMATION

(Check appropriate box)

- Most recent 3 year history
 Any and all records
 Other _____
 Other _____

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.

(Minors-A minor patient's signature is **required** in order to release the following information (1) conditions relating to the minor's reproductive care including, but not limited to, contraception, pregnancy and sexually transmitted diseases (age 14 and older), (2) alcohol and/or drug abuse (age 13 and older) and (3) mental health conditions (age 13 and older)) WAC275-56-240 RCW 71.05

SPECIFIC RELEASE - REQUIRED TO EXCLUDE

This release **MAY NOT** include specific information related to testing, diagnosis, and or treatment for HIV, sexually transmitted diseases, psychiatric disorders/mental health, or drug and alcohol use. (If I choose to exclude this information, I understand it will take longer to process my request for records).

SIGNATURE _____

REASON(S) FOR THIS AUTHORIZATION (CHECK ALL THAT APPLY):

At my request Transferring Care Other (specify): _____

THIS AUTHORIZATION ENDS:

In 90 days from the date signed On (date): _____
 When the following event occurs: _____

(No longer than 90 days from date signed)



AUTHORIZATION FOR THE DISCLOSURE OF MY HEALTH CARE INFORMATION *page 2*

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.
- 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.
- Write a letter to the Center for Women's Health at Evergreen.

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

Patient or legally authorized individual signature

Date

Time

Print your name (if signed on behalf of the patient)

Relationship (parent, legal guardian, personal representative)

PROVIDER INITIAL: _____ DATE: _____

PROVIDER COMMENTS: _____

Last update: 3/19/04

