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