PATIENT AUTHORIZATION TO DISCLOSE, RELEASE AND/OR OBTAIN PROTECTED HEALTH INFORMATION

1. Patient Information

Name-Last, First, MI		Former Name(s)/Alias:	
Street Address:	City:	State:	Zip:
Medical Record Number (if known)	Date of Birth:	Phone Number:	

2. Purpose or need for disclosure

☐ Transfer of care ☐ Insurance ☐ Legal ☐ Personal ☐ Other(specify)_____

3. Records to be released from:

Organization or Business Name (if applicable)			
Address:	City:	State:	Zip
Telephone (include area code)	Fax Number (include area code)	Email Address:	

4. Records to be disclosed to: (e.g. Insurance Company, Attorney, Physician, Patient)

Name-Last, First, MI	Title		
Organization or Business Name (if applicable)			
Address:	City:	State:	Zip
Telephone (include area code)	Fax Number (include area code)	Email Address:	

5. RECORDS to be disclosed:

☐ **Comprehensive overview of chart** (contains discharge summaries, admit note, history & physical, operative note, emergency department note, pathology reports, clinic summaries, radiology/diagnostic reports, EKG, and lab reports) from date:_____ to date:_____
(if timeframe not specified most recent 2 years of medical records will he provided)
☐ **Images** (specify type – e.g. radiology, endoscopy, mammogram, DEXA)
☐ **Other** (specify
required) – e.g. discharge summary, immunizations, operative reports, lab reports, billing records, colonoscopy, or entire health record)

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6. PLEASE NOTE: If your client or other confidential records include any of the following information, you must also complete the below section to allow disclosure of these records.

Patient Authorization: Unless 0therwise indicated, I authorize sensitive information about my conditions which may include HIV/AIDS and STD test results, diagnosis or treatment records (RWC 70.02.220) Mental health records (RWC 70.02.230 or 240) Chemical Dependency (CD) records (42 CFR Part 2) ☐ **DO NOT INCLUDE SENSITIVE INFORMATION.**

7. Authorization is in effect until _____(date) OR when the following event occurs: _____(date)

• This permission is valid for 1 year or until (date or event, if not checked, will be 1 year).
• I may revoke or withdraw my permission in writing at any time, but that will not affect information already produced.
• I understand that my records may no longer be protected under the laws that apply to Pioneer Family Medicine after this they are produced.
• A copy of this form is valid to give my permission to disclose records. **Pioneer Family Medicine** may charge to provide copies of its records

Authorized by (Signature):	**Date Signed:**	**Telephone (with area code):**
Print Name:	**Witness/Notary (sign and print name)**	

If I am not the person who is the subject of the records, I am authorized to sign because I am the: (attach proof of authority)
☐ Parent of minor ☐ Legal Guardian ☐ Personal Representative ☐ Other:

Notice to those receiving information: If these records contain information about HIV, STDs, or alcohol or drug abuse, you may not further disclose that information under federal and state law without specific permission of the subject and meeting specific legal requirements as required by RCW70.02.300/42 CFR2.32:

Instructions for Completing

Patient Authorization to Disclose, Release or Obtain Protected Health Information

Item #1 (Patient Information): The name, birthdate, phone number and Medial Record Number (if known) of the patient.

Item #2 (Purpose): Indicate any and all purposes for disclosure.

Item #3 (Records to be released from): Identify the holder of records to be released or for services provided.

Item #4 (Records to be disclosed to): Identify the specific person(s) or class(es) of persons who are to receive the information.

Item #5 (Information to be disclosed):

- "Comprehensive" will be the last two years unless a specific time frame is noted.
- "images" box is used to request specific images
- "Other" box is to specify additional

Please be advised that you will be provided a copy of records that were requested and authorized as of the date of the authorization. These records will be generated from the Legal Health Record of Pioneer Family Medicine. With the electronic health information being created and generated in real time we do our best to ensure the record provided to you contains all the documentation entered by the clinicians involved in the patient's care. If you feel that you did not receive a complete set of the information requested please feel free to reach out to Heath Information Department at Pioneer Family Medicine.

Item #6 (Release of confidential records) please make sure you mark the following:

- **DO NOT INCLUDE SENSITIVE INFORMATION** if you do not wish information to be released.

Item #7 (Expiration): If "Other expiration event" is selected, the event must be one that is related to the patient. (e.g., if the authorization is for disability determination, the authorization might end when the determination has been finalized). Ordinarily, a specific date is preferable.

Signatures:

In general, a patient age 18 or older has legal authority to sign this form. For patients younger than 18, generally the patient's parent or legal guardian must sign on behalf of the patient. There are many exceptions under Washington State law to these general rules. (Example-The patient is permitted to sign this form regardless of age for disclosures of patient information related to reproductive health: If the patient is age 14 or older, the patient may authorize disclosure of HIV test results: If the patient is age 13 or older, the patient may authorize disclosure of outpatient mental health treatment.)

For deceased patients, this form may be signed by the patient's surviving spouse or personal representative.

All individuals signing for use or disclosure of medical information on behalf of a patient must state their relationship to the patient and may be required to provide proof of legal authority to permit the use or disclosure of the medical information.

Note:

Pioneer Family Medicine has AdvancedMD electronic medical records which provides a secure and convenient way to Access many different types of personal health information in your impatient or outpatient medical records. This Include: Current medicines, Allergies, Immunizations (vaccines), Medical History, test results, details of your previous Clinic visits and hospital discharge instructions.