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)	Birthdate	Phone Number	

2. Purpose or need for disclosure - may be released electronically. (Please check all applicable categories)

☐ Attorney ☐ Insurance ☐ Provider ☐ Personal ☐ Other (specify)_____

3. Records to be released from:

☐ Harborview Medical Center & Clinics
☐ UW Medical Center & Clinics – Montlake
☐ UW Medicine Primary Care
☐ UW Medical Center & Clinics – Northwest
☐ Valley Medical Center & Clinics
☐ Hall Health Center
☐ Other: _____

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

Name	Telephone	Fax#	
Street Address	City	State	Zip

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 be provided)

☐ **Images** (specify type – e.g. radiology, endoscopy, **will be on CD**) _____

☐ **Other** (**specify type (required)** – e.g. discharge summary, operative reports, lab reports, billing records, or entire legal health record.)

AND/OR:

☐ **I authorize VERBAL COMMUNICATION ONLY about my medical history and care.** (Checking this box means no physical records will be sent unless otherwise indicated by checking additional boxes in sections 5 and 6.)

Patient Authorization: Unless otherwise indicated, I authorize sensitive information about my conditions which may include sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). My health record may also include sensitive information about behavioral or mental health services and treatment for alcohol and drug abuse. ☐ **Do not include this sensitive information**.

6. Format for Records: ☐ CD/DVD (requires PDF viewer) OR ☐ Paper ☐ MyChart **Please note, if a format is not selected, records will be provided in CD/DVD**. If VERBAL COMMUNICATION ONLY, this item may be skipped.

7. This authorization is in effect until _____ (date) **OR** when the following event occurs: _____
(State when UW Medicine is no longer authorized to disclose my information based on this authorization. If no date or event is listed above, this authorization is valid for three years from the date on which it is signed.)

Note: Authorizations to disclose your information to an employer or financial institution can only be effective for a maximum of one year from the date signed by you.

Signature (Patient Or Person Authorized To Give Authorization)	Date
If Signed by Person Other Than Patient, Provide Printed Name, Reason, Relationship to Patient, Description of Their Authority	

PLACE PATIENT LABEL HERE

UW Medicine
Harborview Medical Center – University of Washington Medical Center
UW Medicine Primary Care – Valley Medical Center – UW Physicians

AUTH TO DISCLOSE/OBTAIN PHI

U0626

WHITE – MEDICAL RECORD
CANARY – PATIENT

By signing this page, I acknowledge that I have read and agree to the terms on both sides of this form.

Patient Authorization to Disclose, Release or Obtain Protected Health Information

Minors: A minor patient's signature is required in order to release the following information (1) conditions relating to the minor's reproductive care (2) sexually transmitted diseases (if age 14 and older), (3) alcohol and/or drug abuse and mental health conditions (if age 13 and older).

Patient Rights: I understand I do not have to sign this authorization in order to obtain healthcare benefits (treatment, payment, or enrollment). I may revoke this authorization at any time except to the extent already relied upon by sending a request in writing to UW Medicine Compliance Office Box 358049, Seattle, WA 98195. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under privacy laws.

I understand I have the following rights to:

- Inspect or to receive a copy of my protected health information
- Receive a copy of this signed form
- Refuse to sign this form for authorization to disclose or release my protected health information

I also understand UW Medicine will not base treatment or payment decisions on receipt of this signed authorization, except in these cases: (1) UW Medicine may condition research-related treatment on my signing or my providing an authorization for the use or disclosure of my information for such research **or** (2) UW Medicine may condition the provision of healthcare that is just for the purpose of creating protected health information for disclosure to a third party on my signing or my providing an authorization for the disclosure of the health information to such third party. An example of this is when a non-UW employer contracts with UW Medicine to conduct TB testing for purposes of employee health screening.

This authorization form can be sent to us by mail or by fax. If the patient chooses to accept the risks associated with unencrypted email (that email communications could potentially be read by a third party), the form may be sent by email:

Harborview Medical Center and Clinics
UW Medical Center and Clinics – Montlake
UW Medical Center and Clinics – Northwest
UW Medicine Primary Care Clinics
Hall Health Center
Mail: 325 Ninth Ave., Box 359738
Seattle, WA 98104

Fax: (206) 744-9997
Phone: (206) 744-9000
Email: uwmedroi@uw.edu

Valley Medical Center and Clinics
Mail: Release of Information
400 S. 43rd Street
P.O. Box 50010
Renton, WA 98058

Fax: (425) 690-9407
Phone: (425) 690-3406
Email: RecordsRequest@valleymed.org

PLACE PATIENT LABEL HERE

Instructions for Completing

Patient Authorization to Disclose, Release or Obtain Protected Health Information

Item #1 (Patient Information): The name, birthdate, phone number and Medical 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 are 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 - All selections potentially include verbal communication about the records disclosed): choose what information is permitted for disclosure.

- If "Images" box is used, specify type of images.
- The "VERBAL COMMUNICATION ONLY" option can be used to permit conversations with designated person(s) identified in item #4.
- If "Other" box is used, description must be reasonably detailed.

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 which in some instances involves a hybrid record which may contain some paper as well as data and medical information and treatment records from multiple Electronic health record systems. With the electronic health information being created and generated in real time by multiple users 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 should feel that you did not receive a complete set of the information requested please feel free to reach out to the Health Information Department.

Item #6 (Format for Records): indicate format desired. If both formats are needed, check both boxes.

Item #7 (Expiration): if "Other expiration event" is selected, the event must be one that is related to the patient (example - termination of patient's treatment, patient's death) or to the purpose for the authorization (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. (Examples – 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:

UW Medicine MyChart (https://mychart.uwmedicine.org) is a free, secure and convenient way to access many different types of personal health information in your inpatient or outpatient medical records. This information may include: Current medicines, Allergies, Immunizations (vaccines), Medical history, Test results, Details of your previous clinic visits, Hospital discharge instructions.