Patient Authorization to Release a Machine-Readable Export of Protected Health Information

Please use this form only to request an export of your records in a **machine-readable format**. This export contains medical record data from all UW Medicine and Fred Hutchinson Cancer Center locations because those entities share an Electronic Health Record (EHR), called Epic. Records provided in this format cannot be filtered by date or restricted to a specific date range. Records can only be provided in this format if they are stored within the Epic system. For that reason, the following are excluded from the export:

- Records that are stored outside of Epic, including most images and most documents, cannot be included in this export. Images include radiology images and eye images, and documents include paper forms scanned into the EHR, such as consent forms and questionnaires.
- Historical records (all records prior to 3/27/21, with the exception of some clinics) are not stored in Epic and cannot be provided in this format.
- Records from Valley Medical Center are excluded because they are on a separate instance of the Epic EHR. If you need records from Valley Medical Center, please call: 425-690-3406 or email RecordsRequest@valleymed.org.

To request medical and billing records in a human-readable PDF format, including those excluded from this export, please go to: https://www.uwmedicine.org/patient-resources/access-medical-records-images.

1. Patient Information

Name – Last, First, MI	Former Name(s)/Alias		
Street Address	City	State	Zip
Email Address	Birthdate	Phone	

2. Purpose of Request

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

3. Recipient of Records (e.g., Insurance Company, Attorney, Physician, Patient)

Name	Attention To	Phone	Fax	Email	
Street Address		City		State	Zip

4. Sensitive Information Disclosure

I authorize sensitive information about my conditions which may include sexually transmitted diseases and HIV/AIDS/AIDS-related illnesses. My health record may also include sensitive information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand that sensitive information cannot be excluded from this export.

***Optional* Please check below if you would like medical records from these units released. Medical records directly related to your care from these units are excluded by default, but some information may be released even if you do not make a selection if referenced elsewhere in your chart. This section does not apply to billing records.**

☐ Sexual Assault Nurse Examination Records
☐ Living Donor Records
☐ Harborview Abuse and Trauma Center Records
☐ Hall Health Mental Health Records

PLACE PATIENT LABEL HERE

WHITE – MEDICAL RECORD
CANARY – PATIENT

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5. This authorization is in effect until _____ (date) **OR** when the following event occurs: _____.
(If no date/event is provided, the authorization will be valid for three years from the signature date. Authorizations to disclose your information to an employer or financial institution may only be effective for one year.)

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	

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

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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, it may no longer be protected under privacy laws and it may be re-disclosed.

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 postal mail, email, or fax to:

Harborview Medical Center and Clinics
UW Medical Center and Clinics—Montlake
UW Medical Center and Clinics—Northwest
UW Medicine Primary Care
UW Physicians
Hall Health Center

Mail: Enterprise Records and Health Information
Box 354914
1959 N.E. Pacific St.
Seattle, WA 98195
Fax: (206) 744-9997
Phone: (206) 744-9000
Email: uwmedroi@uw.edu

PLACE PATIENT LABEL HERE

WHITE – MEDICAL RECORD
CANARY – PATIENT

Instructions for Completing

Patient Authorization to Release a Machine-Readable Export of Protected Health Information

Item #1 (Patient Information): The name, former name(s) and alias (if any), full address, birthdate, phone number and email address of the patient.

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

Item #3 (Recipient of Records): Identify the specific person(s) or class(es) of persons who will receive the information.

Item #5 (Expiration): If an event is specified, 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 aged 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. However, Washington State law has exceptions to these general rules. For example, the patient is permitted to sign this form regardless of age for disclosures about their reproductive health; patients aged 14 or older may authorize disclosure of HIV test results; and patients aged 13 or older 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 (for example, administrator or executor of the estate).

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.