Patient Authorization to Disclose, Release and/or Obtain Protected Health Information

Patient Name: _____ Date of Birth: _____ Telephone #:_____

Purpose of Disclosure:
☐ Attorney ☐ Insurance ☐ Provider ☐ Personal ☒ Other *(specify)* Evaluation of claim

INFORMATION TO BE RELEASED FROM:

☒ Harborview Medical Center & Clinics
☐ Northwest Hospital and Medical Center & Clinics
☐ Valley Medical Center & Clinics
☐ UW Medical Center & Clinics
☐ UW Neighborhood Clinics
☐ Hall Health Primary Care Center

OR:

_____ *(Org/Person)*

_____ *(Address)*

_____ *(City, ST, Zip)*

_____ *(Phone/Fax)*

INFORMATION TO BE RELEASED TO:

_____ *(Org/Person)*

c/o Compex Legal Services *(Address)*

325Maple Ave Torrance, CA 90503 *(City, ST, Zip)*

800-230-5345 / 800-972-8436 *(Phone/Fax)*

OR:

☐ Harborview Medical Center & Clinics
☐ Northwest Hospital and Medical Center & Clinics
☐ Valley Medical Center & Clinics
☐ UW Medical Center & Clinics
☐ UW Neighborhood Clinics
☐ Hall Health Primary Care Center

If requesting a copy of your own records, how would you like to receive the information? ☒ **Paper** ☒ **CD**

Type of Information ***(check appropriate box):***

☐ **Summary of Visit/Chart notes from date: _____ to date: _____**
☐ **All Medical Records from date: _____ to date**: _____
☒ **All Medical Records**
☐ **Images** *(specify type – radiology, endoscopy, e.g.)* _____
☒ **Other** *(specify type – discharge summary, operative reports, lab reports, billings, e.g.)* Billing records

☐ **I authorize VERBAL COMMUNICATION about my medical history and care.**

OR:

☐ **I authorize VERBAL COMMUNICATION ONLY about my medical history and care.** *(Checking this box means no physical records will be sent.)*

Patient Authorization: I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric condition.

I give my specific authorization for this information to be released: Yes___ No___

This authorization is valid 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.

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

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

PT.NO

NAME

DOB

Place EPIC Label Within Box

UW Medicine
Harborview Medical Center – Northwest Hospital & Medical Center
Valley Medical Center – UW Medical Center
University of Washington Physicians Seattle, Washington

AUTH TO DISCLOSE/OBTAIN PHI

U0626

WHITE – MEDICAL RECORD
CANARY – PATIENT

UH0626 REV FEB15

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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, 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:

Harborview Medical Center
UW Medical Center
UW Medicine Neighborhood Clinics
Hall Health Center
Mail: 325 Ninth Ave., Box 359738
Seattle, WA 98104
Fax: (206) 744-9997
Phone: (206) 744-9000

Northwest Hospital & Medical Center
Mail: 1550 North 115th St., MS-D129
Fax: (206) 368-1920
Phone: (206) 368-1616
Seattle, WA 98133

Valley Medical Center
Mail: Release of Information
M/S VMC 3-006
P.O. Box 50010
Renton, WA 98058-5010
Fax: (425) 656-4026
Phone: (425) 251-5159

PT.NO

NAME

DOB

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Valley Medical Center – UW Medical Center
University of Washington Physicians Seattle, Washington

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