WOMEN'S & FAMILY HEALTH SPECIALISTS

- Obstetrics
- Gynecology
- Family Medicine

1412 SW 43rd Street, Suite 200
Renton, Washington 98057
Telephone 425.271.4910
Fax 425.264.1041

Authorization to Release Protected Health Information

Please fill out form COMPLETELY to be sure that your MEDICAL RECORDS are not delayed.

Patient name: _____ Date of birth: _____

Previous name(s): _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

_____ All health care information in my medical record

_____ Health care information in my medical record relating to the following treatment or condition:

_____

_____ Health care information in my medical record for the date(s): _____

_____ Other (e.g., X-rays, bills), specify date(s): _____

You MAY NOT disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

____ Sexually transmitted diseases (includes AIDS/HIV) ____ Psychiatric disorders/mental health ____ Drug and/or alcohol use

You may DISCLOSE this health care information:

TO:

Name/Organization:_____

Address: _____

City: _____

State: _____**Zip:** _____

Ph: _____ **Fax:** _____

You may REQUEST this health care information:

FROM:

Name/Organization:_____

Address: _____

City: _____

State: _____**Zip:** _____

Ph: _____ **Fax:** _____

Reason(s) for this authorization (check all that apply): (Charges for copies of records may apply, see back for information)

_____ Continuing Care Doctor _____ Transfer of Care _____ Personal/Own Use _____ Insurance

_____ other (specify) _____

This authorization ends:

_____ on (date): _____ when the following event occurs: _____

_____ in 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes other than payment)

II. 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 Women's & Family Health Specialists 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 Medical Records Department Or
- Write a letter to Women's & Family Health Specialists.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____

Patient or legally authorized individual signature Date Time

OVER →

_____ _____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

AUTHORIZED PERSONAL REPRESENTATIVE FOR PATIENTS NOT COMPETENT

A personal representative is an individual that may act on behalf of a patient when a patient is not competent and cannot make his or her own health care treatment decisions. In most cases, the personal representative needs legal documentation to demonstrate their authority to sign for the patient. A member of one of the following classes of persons may sign for a patient who is not competent to consent, stated in the following order of priority: (a) The appointed guardian of the patient, if any; (b) The individual, if any, to whom the patient has given a durable power of attorney that includes the authority to make health care decisions; (c) The patient's spouse; (d) Children of the patient who are at least eighteen years of age; (e) Parents of the patient, if unanimous; and (f) Adult brothers and sisters of the patient, if unanimous. If a person is not available in a given class to provide authority regarding health care decisions, then a person (or group of persons acting as one) must be found in the next successive class. [RCW 7.70.065].

REASONABLE AND CUSTOMARY FEES BELOW, AS SET FORTH BY WASHINGTON STATE UNIFORM HEALTH CARE INFORMATION ACT [RCW 70.02 SECTION102 (12)] AND WAC 246-08-400

I AM REQUESTING THE FOLLOWING:

_____ Women's & Family Health Specialists is referring me to another health care provider.
Please copy the necessary records and forward them directly to the physician listed on the front of this form (no charge).

_____ Please send most recent **2 years** worth of medical records directly to my provider listed on the front of this release (no charge).

_____ Please send the most recent **2 years** worth of my medical records directly to **ME**. I am enclosing the **$23.00** FLAT clerical processing fee. I understand that my records will be copied and mailed to me within fifteen working days.

_____ Please send a copy of my **ENTIRE** medical record directly to **ME**. I understand that I will be contacted with the amount due for copying fees and that upon receipt of that fee; my records will be sent out within fifteen working days.
($23.00 Clerical Processing Fee *plus $1.04 per page up to the first 30 pages and $.79 cents per page for all other pages*)

PATIENT PRINTED NAME: _____

PATIENT SIGNATURE: _____ DATE: _____