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): ____

FAX RECORDS TO 425-264-1041

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 use or 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

____

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

INFORMATION PROTECTED BY STATE / FEDERAL LAW

State and federal laws protect Mental Health, Alcohol and Drug Abuse, Sexually Transmitted Diseases (Including HIV/AIDS), psychotherapy notes and certain Minor Treatment Records. Disclosures of these types of information require specific patient authorization.

DRUG AND ALCOHOL ABUSE TREATMENT INFORMATION *

Federal regulations (42 C.F.R. part 2) prohibit any further disclosure of this information except with specific written consent of the person to whom the information pertains or the parent or legal guardian of a minor child to whom it pertains, unless otherwise permitted by federal and state law. A general authorization for the release of information is not sufficient for this purpose. This consent is subject to revocation at any time except to the extent that the program, which is to make the disclosure, has already taken action in reliance on it. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient. Federal regulations state that any person who violates any provision of the law shall be fined not more than $500 in the case of a first offense and not more than $5,000 in the case of each subsequent offense. (See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee3.)

MENTAL ILLNESS INFORMATION **

State law prohibits any further disclosure of mental illness information without specific written consent of the person, to whom the information pertains, or the parent or legal guardian or a minor child to whom it pertains, unless otherwise permitted by State Law. A general authorization to release information is NOT sufficient for this purpose.
(See RCW 71.05.390 through RCW 71.05.410.)

SEXUALLY TRANSMITTED DISEASE INFORMATION (includes HIV / AIDS) ***

State law prohibits any further disclosure of sexually transmitted disease information without specific written consent of the person, to whom the information pertains, or the parent or legal guardian of a minor child to whom it pertains, unless otherwise permitted by State Law. A general authorization is NOT sufficient for this purpose. Any violation of the law is a gross misdemeanor, and the law creates civil remedies for any violation which includes a $1,000 fine for a negligent violation, a $2,000 fine for an intentional or reckless violation or actual damages, whichever is greater, and attorney fees. [RCW 70.24 and WAC 248-100.]

CONSENT OF MINOR ****

Where a minor has the right to consent to medical treatment, he or she also has the right to control information related to that treatment. A competent minor patient's signature is required to release information related to care of: 1) birth control for minors deemed mature [WA case law]; 2) treatment for HIV/AIDS sexually transmitted diseases for patients age 14 and above; [RCW 70.05.070, RCW 70.24.110]; 3) to receive HIV/AIDS or STD test results for patients age 15 and above [RCW 70.24.105]; 4) outpatient treatment for alcoholism and drug abuse for patients age 13 and above; [RCW 70.96A.095]; and 5) mental health conditions for patients age 13 and above [RCW 71.34.030(1)]

PSYCHOTHERAPY NOTES

Federal law prohibits an authorization for release of information pertaining to psychotherapy notes from being combined with an authorization for release of any other kind of records. [45 CFR 164.508(b) (3) (ii)]

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 the 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 $1.02 per page up to the first 30 pages and $.78 cents per page for all other pages*

PATIENT PRINTED NAME: ____

PATIENT SIGNATURE: ____ DATE: ________________________