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

Recent medical records are available via MyChart for immediate download without filling out this form. See page 3 for more information.

## 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 ☐ PFMLA
☐ Provider ☐ Personal ☐ Other (specify) _____

## 3. Facilities to Release Records

☐ Harborview Medical Center & Clinics ☐ UW Medical Center & Clinics—Northwest ☐ UW Medicine Primary Care
☐ Valley Medical Center (VMC) & Clinics ☐ UW Medical Center & Clinics—Montlake ☐ UW Physicians

Provider/Clinic (Please send this form directly to non-UW Providers): _____
Address: _____ Phone: _____ Fax: _____

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

| Name | Attention To | Phone | Fax | Email |
|---|---|---|---|---|
| Street Address | | City | State | Zip |

## 5. Records to be Disclosed: Date Range: _____ to _____ OR ☐ Most Recent 2 Years (default if no dates listed)

☐ Medical Records ☐ Billing Records ☐ Immunizations ☐ Radiology Images
☐ Clinic Notes ☐ Labs and Pathology ☐ Procedures ☐ Radiology Reports
☐ Other (please specify): _____
☐ **AND/OR: I authorize VERBAL COMMUNICATION ONLY about my medical history and care.**

*This authorization permits UW Medicine to release information related to sexually transmitted diseases, HIV/AIDS/AIDS-related illnesses, behavioral or mental health services, and treatment for alcohol and drug abuse.*

***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 ☐ Harborview Abuse and Trauma Center Records
☐ Living Donor Records ☐ Hall Health Mental Health Records

## 6. Format for Records: If verbal communication only, skip this item.

**NOTE**: Radiology Images are on CD, and require DICOM viewer.

☐ CD/DVD (required PDF viewer) ☐ Paper ☐ MyChart ☐ USB/Thumb Drive ☐ Email (see page 3)

## 7. 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.)

**By signing the above page, I acknowledge that I have read and agree 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 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

**AUTHORIZATION TO DISCLOSE/OBTAIN PHI**



WHITE – MEDICAL RECORD
CANARY – PATIENT

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**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, 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.**

**Harborview Medical Center and Clinics**
**UW Medical Center and Clinics—Montlake**
**UW Medical Center and Clinics—Northwest**
**UW Medicine Primary Care**
**UW Physicians**
**Husky Health Center** (formerly 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

**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

**Request for Billing Records (non-VMC)**
Mail: Patient Accounts & Support Services
7527 63rd Ave. NE—Building 5C
Seattle, WA 98115
Phone: (206) 520-0400 **or** (800) 520-0400
Email: passroi@uw.edu

# *Instructions for Completing*
# Patient Authorization to Disclose, Release or Obtain 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 (Facilities to release records)** Identify the facilities who hold the health records that are to be released. Select one or more checkboxes and specify a campus such as Harborview, UWMC Montlake Campus, UWMC Northwest Campus, or UW Primary Care Clinics and/or clinic(s) (if desired) in the free text box.

**Item #4 (Recipient of Records):** Identify the specific person(s) or class(es) of persons who will receive the information.

**Item #5 (Records to be disclosed):** Note: All selections potentially include verbal communication about the records disclosed. Choose what information is permitted for disclosure.

- Select "Most Recent 2 Years" or specify the date range of records to be released. If no selection is noted, records from the most recent 2 years will be released.
- The "VERBAL COMMUNICATION ONLY" option can be used to permit conversations with designated person(s) identified in item #4.
- If no selection is made in the "Optional" box, records from those units will **not** be released.

**Item #6 (Format for Records):** Indicate format(s) desired. If email is selected, the patient understands and accepts the potential risks of email communication. Emails are subjected to file size restrictions. For more information about the risks of email, visit https://www.uwmedicine.org/about/policies-and-notices/email-risk.

**Item #7 (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.

**Completeness**: The recipient will be provided a copy of records that were requested as of the date of your authorization. These records will be generated from the Legal Medical Record which in some instances involves a hybrid record which may contain some paper as well as medical information from multiple electronic health record systems. Because electronic health information is being created and generated in real time by multiple users, we do our best to ensure the records released contain all the documentation entered by the clinicians involved in the patient's care. If you believe you did not receive all of the information requested, please contact the Health Information Department.

**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.

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