

AUTHORIZATION FOR UW MEDICINE TO DISCLOSE/RELEASE PROTECTED HEALTH INFORMATION

PLEASE READ AND COMPLETE THE ENTIRE FORM IN ORDER FOR UW MEDICINE TO PROCESS THIS REQUEST

I authorize the following UW Medicine entities*: _____

Please choose the entities you authorize to disclose information:

* University of Washington Medical Center & Clinics, Harborview Medical Center & Clinics, UW Medicine Neighborhood Clinics, University of Washington Sports Medicine Clinic, UW Medicine Eastside Specialty Center, Hall Health Primary Care Center, or University of Washington Physicians (billing records only).

to disclose protected health information about:

_____, _____
 NAME OF PATIENT BIRTHDATE
 for health care provided beginning _____ and ending _____
 DATE DATE

The purpose of the disclosure is: _____

- or - The disclosure is made at the request of the individual

Expiration of Authorization:

This authorization expires on _____ (date) OR when the following event occurs: _____ (State when you want UW Medicine to stop disclosing information based on this authorization).

Note: Authorizations to disclose your information to an employer or financial institution can only be effective for a maximum of 90 days from the date signed by you.

Verbal and/or Written Information to be Disclosed:

PLEASE CHECK ALL APPROPRIATE BOXES:

- | | | |
|---|--|--|
| <input type="checkbox"/> ALL RECORDS | <input type="checkbox"/> DISCHARGE SUMMARY | <input type="checkbox"/> RADIOLOGY RECORDS |
| <input type="checkbox"/> SUMMARY OF MEDICAL HISTORY / TREATMENT | <input type="checkbox"/> CONSULTATION | <input type="checkbox"/> RADIOLOGY FILMS |
| <input type="checkbox"/> LABORATORY / DIAGNOSTIC TESTS | <input type="checkbox"/> EKG REPORT | <input type="checkbox"/> EEG REPORT |
| <input type="checkbox"/> PSYCHOLOGICAL TESTING | <input type="checkbox"/> PATHOLOGY REPORT(S) | <input type="checkbox"/> OPERATIVE REPORT |
| <input type="checkbox"/> PATHOLOGY SPECIMEN(S) / SLIDE(S) | | |
| <input type="checkbox"/> OTHER (Please Specify): _____ | | |

I understand the information in my health record may include sensitive information relating to my conditions. These may include sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). My health record may also include sensitive information about behavioral or mental health services and treatment for alcohol and drug abuse.

If I choose to exclude the sensitive information by checking the box below, I understand I may be charged an additional fee to remove the sensitive information.

Person / Organization to receive the information for the purpose described:

NAME OF PERSON / ORGANIZATION	COMPLETE ADDRESS / PHONE

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, please print your name, provide reason, relationship to patient, & description of authority	

PT.NO

NAME

DOB

UW Medicine
 Harborview Medical Center – UW Medical Center
 University of Washington Physicians
 Seattle, Washington

AUTH TO DISCLOSE PHI

U0626

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WHITE – MEDICAL RECORD
 CANARY - PATIENT

A U T H O R I Z A T I O N — G R A Y

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POTENTIAL FOR REDISCLOSURE: Once your health information has been disclosed, the law does not always require the receiver of your information to keep your information confidential.

REVOCAION: I understand I may revoke this authorization by submitting the revocation request in writing to UW Medicine Privacy Office, Box 359210, Seattle, WA 98195, at any time. Any revocation will not take effect if action has already been taken based on the original authorization, or in case UW Medicine requires the information in order to be paid for treatment provided to me.

I understand I have the following rights: a) To inspect or to receive a copy of my protected health information, b) To receive a copy of this signed authorization and c) To refuse to sign this authorization.

I also understand UW Medicine will not base treatment or payment decisions based on receipt of this signed authorization, except in the following: (1) UW Medicine may base 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 base health care that is just for the purpose of creating 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.

FOR OFFICE USE ONLY:

INFORMATION REQUESTED	DATES
1. ALL RECORDS	
2. DISCHARGE SUMMARY	
3. RADIOLOGY REPORT	
4. RADIOLOGY FILM	
5. EKG REPORT	
6. EEG REPORT	
7. PSYCHOLOGICAL TESTING	
8. OPERATIVE REPORT	
9. PATHOLOGY REPORT	
10. PROGRESS NOTES	
11. CONSULTATION	
12. LABORATORY REPORT	
13. OTHER	
SENT BY:	DATE SENT:

PT.NO

NAME

DOB

UW Medicine
 Harborview Medical Center – UW Medical Center
 University of Washington Physicians
 Seattle, Washington

AUTH TO DISCLOSE PHI

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AUTHORIZATION — GRAY