

AUTHORIZATION FOR UW MEDICINE TO OBTAIN PROTECTED HEALTH INFORMATION FROM ANOTHER HEALTH CARE PROVIDER

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

I authorize _____,
NAME OF DISCLOSING ENTITY

_____,
ADDRESS OF DISCLOSING ENTITY PHONE NUMBER OF DISCLOSING ENTITY

to use and disclose to UW Medicine* protected health information about:

_____,
NAME OF PATIENT BIRTHDATE

for health care provided beginning _____ and ending _____
DATE DATE

Expiration of Authorization:

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

Information to be Obtained (Describe what medical information can be disclosed to UW Medicine):

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.

I choose to exclude the sensitive information from this disclosure by checking this box.

These Person(s) at UW Medicine will receive the information for the purpose(s) described:

NAME OF PERSON / ORGANIZATION	COMPLETE ADDRESS / PHONE	PURPOSE

* UW Medicine includes the following entities: 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.

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, PRINT NAME, PROVIDE REASON, RELATIONSHIP TO PATIENT, DESCRIPTION OF THEIR AUTHORITY	

PT.NO _____

NAME _____

DOB _____

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

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WHITE – MEDICAL RECORD
 CANARY - VARIABLE

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.

REVOCAATION: 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 to be paid for treatment provided to me.

I understand I have the following rights: a) to inspect or 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 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 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.

PT.NO

NAME

DOB



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

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