

## Patient Authorization to Use and Disclose Protected Health Information for Publication

Please read and complete the entire form in order for UW Medicine to process this request.

I, \_\_\_\_\_ (Patient) **authorize** \_\_\_\_\_  
(name of Workforce Member) of UW Medicine (Harborview Medical Center & Clinics, UW Medical Center & Clinics, Valley Medical Center & Clinics, UW Medicine Neighborhood Clinics, Hall Health Center, University of Washington Physicians)

**To disclose my patient information in the following publications:**

\_\_\_\_\_  
(Describe the types of books, articles, journals, etc., in which the patient information may be published.)

**Description of the patient information that may be disclosed:** \_\_\_\_\_

**Expiration of Authorization: (select one)**

This authorization expires on \_\_\_\_\_ (date) **OR** when the following event occurs: \_\_\_\_\_  
(State when UW Medicine is no longer authorized to disclose my information for publication purposes).

**Required Specific Release:** (This must be completed)

This authorization for release of records may include the release of the following specially protected information unless specifically excluded. Check appropriate boxes if you **DO NOT** want this information released:

- |  |   |                                   |
|--|---|-----------------------------------|
| <input type="checkbox"/> Reproductive care (applicable to minors only) | <input type="checkbox"/> Mental Health              | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Sexually transmitted diseases                 | <input type="checkbox"/> Drug and alcohol treatment |                                   |

Potential for Redisclosure: Once disclosed, the law does not always require the recipient of your information to keep it confidential.

**Revocation:** This authorization may be revoked by submitting a request in writing to:

UW Medicine Compliance  
Box 358049  
Seattle, WA 98195

Note: A request to revoke this authorization will not affect any actions already taken based on the original authorization, or prevent UW Medicine from requiring the information in order to be paid for treatment that you receive.

I understand I have the right 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 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.

**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).

Signature (Patient Or Person Authorized To Give Consent)	Printed Name	Date
If signed by person other than patient, provide 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 USE/DISCLOSE PHI FOR PUBLICATION**

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WHITE – MEDICAL RECORD  
CANARY – PATIENT