Patient Authorization for UW Medicine to Disclose/Release Protected Health Information

Please read and complete the entire form so your request can be processed.

I authorize the following UW Medicine entities:

Please choose the entities you authorize to disclose information:

- ☐ Harborview Medical Center & Clinics
- ☐ University of Washington Medical Center & Clinics
- ☐ Northwest Hospital & Medical Center & Clinics
- ☐ UW Medicine Neighborhood Clinics
- ☐ University of Washington Sports Medicine Clinic
- ☐ Hall Health Primary Care Center
- ☐ Summit Cardiology
- ☐ 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 for: _____

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 UW Medicine is no longer authorized to disclose my 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 that apply

- ☐ Subset Of Medical Record (Narrative documentation, test results, operative reports, outpatient notes)
- ☐ Summary Of Medical History / Treatment
- ☐ Laboratory / Diagnostic Tests
- ☐ Psychological Testing
- ☐ Pathology Specimen(S) / Slide(s)
- ☐ Records From Non-UW Medicine Providers
- ☐ Other (please specify):_____
- ☐ Discharge Summary
- ☐ Consultation
- ☐ EKG Report
- ☐ Pathology Report(s)
- ☐ All Records
- ☐ Radiology Report
- ☐ Radiology Image
- ☐ EEG Report
- ☐ Operative Report

I authorize sensitive information about my conditions which 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 not authorize the sensitive information to be disclosed, I must initial the line below for that information to be excluded and I understand I may be charged an additional processing 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 form, I acknowledge that I have read and agreed to the terms on both sides of this form *Authorization For UW Medicine To Disclose Protected Health Information*

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

Place EPIC Label Within Box

UW Medicine Health System
Harborview Medical Center – UW Medical Center
Northwest Hospital & Medical Center – University of Washington Physicians
Seattle, Washington

AUTH TO DISCLOSE PHI

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WHITE – MEDICAL RECORD
CANARY - PATIENT

***Potential for Redisclosure**:* Once your health information has been disclosed, the law does not always require the receiver of your information to keep it confidential.

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

UW Medicine Privacy Office
Box 359210
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 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 Image	
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

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UW Medicine Health System
Harborview Medical Center – UW Medical Center
Northwest Hospital & Medical Center – University of Washington Physicians
Seattle, Washington

AUTH TO DISCLOSE PHI

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