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
- ☐ Northwest Hospital & Medical Center & Clinics
- ☐ UW Medical Center & Clinics
- ☐ Valley Medical Center & Clinics
- ☐ Hall Health Primary Care Center
- ☐ UW Medicine Sports Medicine Clinic
- ☐ UW Medicine Neighborhood Clinics
- ☐ University of Washington Physicians (billing records only)

to disclose protected health information about:

_____, _____,
Name of Patient Birthdate

for healthcare 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.

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

Name of Person / Organization	Complete Address / Phone

☐ 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

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:

- ☐ Reproductive care (applicable to minors only)
- ☐ Sexually transmitted diseases
- ☐ Mental Health
- ☐ Drug and alcohol treatment
- ☐ HIV/AIDS

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).

By signing this form, 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

Place EPIC Label Within Box

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

AUTH TO DISCLOSE PHI

U0626

UH0626 REV JUN 12

WHITE – MEDICAL RECORD
CANARY - PATIENT

Authorization For UW Medicine To Disclose Protected Health Information

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 Compliance
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 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.

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

Place EPIC Label Within Box

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

AUTH TO DISCLOSE PHI

U0626

UH0626 REV JUN 12 BACK

Patient Authorization for UW Medicine to Obtain Protected Health Information From Another Healthcare 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 Birth date

for healthcare provided beginning _____ **and ending** _____.
Date Date

* UW Medicine includes the following entities: Harborview Medical Center & Clinics, Northwest Hospital & Medical Center and clinics, UW Medical Center & Clinics, Valley Medical Center & Clinics UW Medicine Neighborhood Clinics; UW Medicine Sports Medicine Clinic; Hall Health Primary Care Center; or University of Washington Physicians.

Expiration of Authorization:

This authorization expires on _____ (date) **OR** when the following event occurs: _____ (State when UW Medicine is no longer authorized to receive 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.

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

_____

_____

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:

- ☐ Reproductive care (applicable to minors only)
- ☐ Sexually transmitted diseases
- ☐ Mental Health
- ☐ Drug and alcohol treatment
- ☐ HIV/AIDS

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).

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

Name of Person / Organization	Complete Address / Phone	Purpose

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

Place EPIC Label Within Box

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

AUTH FOR UW MEDICINE TO OBTAIN PHI

U0296

UH0296 REV JUL 12

WHITE – MEDICAL RECORD
CANARY - VARIABLE

Authorization for UW Medicine to Obtain Protected Health Information

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.

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

UW Medicine Compliance
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 following rights to:

- Inspect or receive a copy of my protected health information
- Receive a copy of this signed authorization
- Refuse to sign this authorization

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.