



**ONLY PROPERLY COMPLETED FORMS WILL BE PROCESSED**  
**AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION**  
**TO ANOTHER PROVIDER, OFFICE, OR THIRD PARTY**

Phone: 206-621-4150 • Fax: 206-621-4235  
 1200 - 12th Ave. S., Seattle, WA 98144 • ATTN: ROI

Your name: \_\_\_\_\_

Your address: \_\_\_\_\_

City/State/ZIP: \_\_\_\_\_ Telephone: \_\_\_\_\_

Your date of birth: \_\_\_\_\_ Medical Records Number: \_\_\_\_\_

Charges may apply. Please see page 2 information and initial here: Initials:	<b>PacMed sends out records</b>	I request and authorize Pacific Medical Centers to release information to:  Provider or Organization: _____  Clinic Address: _____  Clinic City/State/Zip: _____  Clinic Phone: _____ Fax: _____	Information to be disclosed is indicated by checked box and is for the following dates of service: _____  <input type="checkbox"/> All / Entire Record <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Consults <input type="checkbox"/> Discharge Summary <input type="checkbox"/> EKG / Cardiology Testing Results <input type="checkbox"/> ER Record <input type="checkbox"/> Eye Exam <input type="checkbox"/> History & Physical <input type="checkbox"/> Home Care Records <input type="checkbox"/> Lab Results <input type="checkbox"/> Mammography <input type="checkbox"/> Medication List - Current <input type="checkbox"/> Operative Report <input type="checkbox"/> Pathology Report <input type="checkbox"/> Progress Notes / Visit Notes <input type="checkbox"/> Radiology Results <input type="checkbox"/> *Behavioral Health Information <input type="checkbox"/> *Human Immunodeficiency Virus (HIV) Information <input type="checkbox"/> *Sexually Transmitted Diseases <input type="checkbox"/> *Substance Abuse Information <input type="checkbox"/> OTHER Please specify: _____
	<b>PacMed receives records</b>	I request and authorize the provider/clinic indicated below to release health information to Pacific Medical Centers:  Provider or Organization: _____  Clinic Address: _____  Clinic City/State/Zip: _____  Clinic Phone: _____ Fax: _____	

The information for which I am authorizing release will be used for:

Coordination of care     Other: \_\_\_\_\_

**I UNDERSTAND THAT:**

- Authorizing the disclosure of the health information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- Unless I specify differently, this authorization will expire 12 months or one year from the date of signature below.
- Once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

**\*SPECIAL AUTHORIZATION (if applicable)**

If you are authorizing the release of information related to the testing, diagnosis, and/or treatment for any of the following conditions, please **sign your initials in front of the section** which describes the type of information to be released.

PATIENT INITIALS	PARENT/GUARDIAN INITIALS	CONDITION	PATIENT INITIALS	PARENT/GUARDIAN INITIALS	CONDITION
		Alcohol and/or drug abuse or dependence			HIV/AIDS
		Mental health			Sexually transmitted disease(s)

**AUTHORIZATION / SIGNATURES**

Date: \_\_\_\_\_ Patient Signature: \_\_\_\_\_

**NOTE: IF THE PATIENT IS 13 YEARS OR YOUNGER AND IS NOT AN EMANCIPATED MINOR, THE PARENT OR LEGAL GUARDIAN MUST SIGN. If the patient of any age is unable to sign the authorization for any reason, a legal representative must sign.**

Date: \_\_\_\_\_ Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_

*(Please send copy of documents)*

\*\*\*\*\*COPY OF COMPLETED AUTHORIZATION FORM MUST BE GIVEN TO PATIENT\*\*\*\*\*

**RELEASE OF RECORDS MAY TAKE UP TO 15 WORKING DAYS.**

**PACIFIC MEDICAL CENTERS WILL ONLY PROCESS VALID AND COMPLETE AUTHORIZATION FORMS.**

**Where to send the completed form:**

- If you complete this form at PMC, you may give it to a clinic staff member to send to the Health Information Department
- If you are completing this form at home, you may mail or fax the form to:

Pacific Medical Center Health Information Department  
Attn: Beacon Hill ROI  
1200 12th Avenue S.  
Seattle, WA 98144

**or fax to:** 206-621-4235

**Where to call with questions:**

- To check status on a request, please call 206-621-4150

**Fee for copying medical records**

If you are requesting a copy for your personal use, a fee will be charged (see fee schedule below). Charges for the copies are in compliance with the Washington Administrative Code (WAC 246-08-400)

0-10 pages, no charge

If more than 10 pages, 0-30 pages, \$1.04 per page

Over 30 pages, \$0.79 per page

**MENTAL HEALTH INFORMATION**

State law ((RCW 71.05.39) prohibits any further disclosure (re-disclosure) of mental health information without specific written consent of the person to whom the information pertains, or the parent or legal guardian of a minor child to whom it pertains, unless otherwise permitted by state law. A general authorization to release information is NOT sufficient for this purpose.

**CONSENT OF A MINOR (RCW 70.96A.230, RCW 70.96A.235, RCW 70.96A.095)**

A minor patient's signature is required on the patient signature line to release the following information only:

- 1) Conditions relating to reproductive care including, but not limited to, birth control and pregnancy-related services and sexually transmitted diseases, including HIV/AIDS (age 14 and older); and
- 2) Substance abuse diagnosis or treatment and mental health conditions (age 13 and older).

A parent or legal guardian signature is required for the release of all other healthcare information for minors.

**PROHIBITION ON RE-DISCLOSURE OF HEALTH INFORMATION**

Federal and state laws prohibit re-disclosure of information concerning drugs and alcohol abuse treatment, sexually transmitted disease information or mental health information without the specific written consent of the person to whom the information pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.