The Everett Clinic
For the whole you.
3901 Hoyt Avenue ■ Everett, WA 98201 ■ 425-259-0966
Health Information Management
Fax: 425-339-5439 Phone: 425-339-5426

INTERNAL USE ONLY:

MRN: _____

ROI Status: ❑ Processed ❑ Returned to Requester ❑ Encounter

❑ Chart Review ❑ Return Letter Date: _____

❑ Document(s) released in accordance with scope of patient request

Date records were provided: _____

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Please read all information and instructions before completing and signing the authorization form.

Patient's Name _____ Birth date _____
(Please Print) LAST FIRST MI

Are medical records filed under another name? _____ Phone Number _____

INFORMATION TO BE RELEASED ***BY:***	INFORMATION TO BE RELEASED ***TO:***
REQUEST MUST HAVE COMPLETE ADDRESS OR FAX NUMBER	**REQUEST MUST HAVE COMPLETE ADDRESS OR FAX NUMBER**
_____ Organization/Person Name	_____ Organization/Person Name
_____ Street Address City, State, Zip	_____ Street Address City, State, Zip
_____ Phone Fax	_____ Phone Fax

TYPE OF MEDICAL INFORMATION REQUESTED:
❑ Complete medical record abstract (includes 3 years of chart notes, most recent labs/pathology & diagnostic imaging reports)
❑ Cancer Partnership records ❑ Radiology/ Diagnostic Imaging (CD/Films) ❑ Mammogram Diagnostic Imaging (CD/Films)
❑ Echocardiograms ❑ Pharmacy ❑ Behavioral Health records only
❑ My health information relating only to the following treatment or condition: _____
❑ My health information only for the following date(s): _____
❑ Other: _____

REASON FOR REQUEST: ❑ Personal ❑ Transfer of Care ❑ Disability ❑ Insurance ❑ Legal Review ❑ Continuing Care
❑ Other (please explain): _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse or self-paid services. You are hereby *specifically authorized to release* all information or medical records relating to such diagnosis, testing, or treatment, unless specifically excluded below.

MINORS AGE 13-17: A minor patient's signature is required in order to release the following information: (1) conditions relating to the minors reproductive care including, but not limited to: contraception, pregnancy, and pregnancy termination, sterilization, and sexually transmitted diseases (age 14 and older), (2) alcohol and/or drug abuse (age 13 and older), and (3) mental health conditions (age 13 and older).

I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization. You have the right to revoke or cancel this authorization, in writing, at any time. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits).

THERE MAY BE A CHARGE FOR COPIES OF YOUR MEDICAL RECORD UNLESS YOUR COPIES ARE BEING SENT TO ANOTHER PHYSICIAN OR HEALTHCARE FACILITY.

This authorization expires _____ (date or event). Authorization will expire in 90 days if not otherwise specified.

Patient signature _____ **Date** _____

Parent or Legal Guardian_____ **Date** _____

Relationship to patient, if other than patient _____
(You may be required to provide legal documentation as proof for power of attorney or guardianship)

Federal and state laws prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains. A general release is NOT sufficient. 42 CFR Part 2: RCW 70.02.300

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MRN: _____

Date of Receipt:

INSTRUCTIONS & IMPORTANT INFORMATION

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Many patients ask The Everett Clinic to communicate by fax. It is the policy of The Everett Clinic to use fax transmissions when necessary for treatment, payment or healthcare operations. By providing The Everett Clinic with a fax telephone number, you are consenting to The Everett Clinic's use of that number for communicating with you by fax.

PATIENT RIGHTS

You have the right to revoke or cancel this authorization, in writing, at any time.

CANCELLATION NOTICE

According to the Uniform Health Information Act for the State of Washington, records shall be released within fifteen days after receipt of a signed, dated release form. Since records are usually handled within 2 – 3 days after receipt, The Everett Clinic will not be held responsible for any release of medical information accomplished before receipt of a written notice of cancellation. Revocation takes place from the date of receipt of written request in the Health Information Management department.

Instructions for Canceling a Request:

1. You must provide a written request to the Health Information Management department asking for revocation/cancellation of the original record release.
2. We need to have your complete name, date-of-birth, telephone number (home/work) and the name of the person/agency that you authorized to receive the medical information.
3. After receipt of the notice by the Health Information Management department, telephone confirmation will acknowledge your withdrawal of authorization.
4. If the release has been accomplished, you will be notified by a representative of the Health Information staff. The release will be revoked for any further disclosure.
5. If you have any questions concerning the cancellation process, call the Health Information Management (Medical Record) Department (425) 339-5426 extension 2171 or 2321.