AUTHORIZATION TO "DISCLOSE/RELEASE" OR "REQUEST" PROTECTED HEALTH INFORMATION

Concerning my protected health information: I authorize *(name of facility, city and state)*:

☐ to release to or ☐ to obtain from *(check one of the UW Employee Health Centers below)*

	ORGANIZATION	COMPLETE ADDRESS / PHONE
	Employee Health Center @ HMC	Box 359855, 325 9th Avenue, Seattle, WA 98104 Phone: (206) 744-3081 / Fax: (206) 744-4886
	Employee Health Center @ UW (Campus)	Box 354410, University of Washington, Steven's Way, Seattle, WA 98195-4410 Phone: (206) 685-1026 / Fax: (206) 221-5110
	Employee Health Center @ UWMC	Box 356122, University of Washington Medical Center, 1959 NE Pacific Street, Seattle, WA 98197-6122 Phone: (206) 598-4848 / Fax: (206) 598-4469

PLEASE READ AND COMPLETE THE ENTIRE FORM IN ORDER TO PROCESS THIS REQUEST

_____, _____,

NAME OF ☐ PATIENT ☐ Employee ☐ Student (Please list other names used) BIRTHDATE

for health care provided beginning _____ and ending_____.

DATE DATE

☐ The purpose of the disclosure is: _____

☐ 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 you want to stop disclosing information according to this authorization).

Oral and Written Information to be Disclosed:

PLEASE CHECK ALL APPROPRIATE BOXES:

☐ SUMMARY OF MEDICAL HISTORY / TREATMENT
☐ LABORATORY / DIAGNOSTIC TESTS
☐ EKG REPORT
☐ OTHER (Please Specify):_____
☐ DISCHARGE SUMMARY
☐ CONSULTATION
☐ IMMUNIZATIONS
☐ PPD
☐ RADIOLOGY RECORDS

I understand that the information in my medical record may include sensitive information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). My medical record may also include sensitive information about behavioral or mental health services and treatment for alcohol and drug abuse. If I choose to exclude the sensitive information by checking the box below, I understand I may be charged an additional fee to remove the sensitive information. ☐

By signing this page, I acknowledge that I have read and agreed to the terms

AUTHORIZATION FOR UW MEDICINE TO DISCLOSE PROTECTED HEALTH INFORMATION

POTENTIAL FOR REDISCLOSURE: Once disclosed, the law does not always require the recipient of your information to maintain the confidentiality of your health care information.

REVOCATION: I understand that I may revoke this authorization by submitting the revocation request in writing to the appropriate CHS Employee Health Center as indicated above, at any time. Any revocation will not be effective to the extent that action has already been taken based on the original authorization, or where UW Medicine requires the information in order to be paid for treatment provided to me.

I understand that I have the following rights:

a) To inspect or to receive a copy of my protected health information,
b) To receive a copy of this signed authorization and
c) To refuse to sign this authorization.

I also understand that the CHS Employee Health Center or a requesting covered entity will not condition treatment or payment based on receipt of this signed authorization, except: (1) UW Medicine may condition research-related treatment on provision of an authorization for the use or disclosure of my information for such research; **or** (2) UW Medicine may condition health care that is solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for the disclosure of the protected health information to such third party; for example, when a non-UW employer contracts with UW Medicine to conduct TB testing for purposes of employee health screening.

SENT BY:	DATE SENT:
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