Authorization to Use/Disclose Health Care Information

ICHS International Community Health Services

Patient Last Name: ______________________ First Name: ________________________ Chart label

Date of Birth: __________________________ Telephone: ____________________ MRN: ______________________________

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☐ International District Clinic
PO Box 3007
Seattle, WA 98114
Phone: (206) 788-3712
Fax: (206) 962-3297

☐ ICHS Vision Clinic
PO Box 3007
Seattle, WA 98114
Phone: (206) 788-3505
Fax: (206) 962-3302

☐ ICHS Legacy House
803 S Lane St
Seattle, WA 98104
Phone: (206) 292-5184
Fax: (206) 292-5271

☐ Holly Park Clinic
3815 S. Othello Street 2nd Fl
Seattle, WA 98118
Phone: (206) 788-3541
Fax: (206) 962-3298

☐ Bellevue Clinic
1050 140th Ave. NE
Bellevue, WA 98005
Phone: (425) 373-3012
Fax: (425) 259-8639

☐ Shoreline Clinic
16549 Aurora Ave. N
Shoreline, WA 98133
Phone: (206) 533-2612
Fax: (206) 962-3299

☐ Seattle World School
Teen Health Center
1700 E Union St
Seattle, WA 98122
Phone: (206) 332-7160
Fax: (206) 568-7128

☐ Highland Middle School
Health Center
15027 Bel-Red Rd
Bellevue, WA 98007
Phone: (425) 373-3135
Fax: (425) 373-3134

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I request and authorize ICHS to ☐ obtain from or ☐ disclose this information to the following entities:

Person or Organization: ____

Address: ____

City/State/Zip: ____

Phone: ______________________ Fax: ______________________

To ☐ obtain or ☐ disclose the following health care information:

From _____________________ to _____________________ (dates of service requested)

☐ All Health Records*

☐ Progress Notes ☐ All ☐ Specify: ______________________

☐ Labs/Dx Test Reports ☐ All ☐ Specify: ______________________

☐ Radiographic/X-Rays ☐ All ☐ Specify: ______________________

☐ Immunization Records ☐ All ☐ Specify: ______________________

☐ OTHER (Please specify): ______________________

In the format requested below: (check the appropriate box)

☐ Paper ☐CD ☐ Fax

☐ Provide copies of health records ☐Disclose health information verbally

For the following purpose(s):

☐ Coordination of Care ☐ Transfer of Care ☐ Personal Use ☐ Legal Matter ☐ Insurance

☐ Other (specify): ______________________

I UNDERSTAND THAT:

*Designating, "All Health Records," above, means the disclosure of my health care information may include information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, chemical dependency or mental health and for patients ages 13-17, information regarding reproductive health care. I give my specific authorization for this information to be released unless I have initialed below to EXCLUDE such information:

_____ HIV/AIDS diagnosis/treatment/testing ______ Reproductive Health Care & Genetics

____ Sexually Transmitted Disease ____ Chemical Dependency treatment ____Mental Health /treatment

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I FURTHER UNDERSTAND THAT:

- I am not required to sign this Authorization in order to receive treatment or to enroll for benefits.
- I may revoke this Authorization in writing at any time except to the extent that the using/disclosing party has already relied on my health care information in good faith.
- Any of my health care information that is disclosed under this Authorization may result in it being re-disclosed by the recipient where it may no longer be protected by state and federal privacy laws.
- I hereby affirm that I understand the effects of signing this Authorization and all of my questions have been answered.
- I am entitled to receive a copy of this Authorization at the time it is signed.
- If I am a personal representative of the patient, I hereby declare that all information regarding my relationship to the patient and my representative authority is true and accurate to the best of my knowledge and that I am legally authorized to sign this Authorization on behalf of the patient. (*Documentation may be required to prove authority to sign on behalf of the patient)
- This authorization will expire on the following date or event: ______________________
- Unless otherwise specified or restricted by applicable law, this authorization will expire one year from the date signed below.

By signing this page, I acknowledge that I have read and agreed to the terms on both sides of this Authorization.

Patient or Legal Representative* Signature: ______________________________ Date: ______________

Print Name: ______________________ Relationship to Patient: ☐ Self; ☐ Other (specify): ______________

Minor Patient Signature: ______________________________ Date: ______________

Note: Signature of minors ages 13-17 is required for certain information

ICHS STAFF ONLY: ☐ Faxed: ☐ Mailed ☐ Picked Up: ______________

Release of records may take up to 15 working days.

ICHS will only process a disclosure request based upon a valid, complete, and signed authorization form.

Medical Records:

International Community Health Services is required by law to maintain the privacy of your health care information, to provide you with a notice of our legal duties and privacy practices, and to follow the information practices that are described in Notice of Privacy Practices (available in six languages).

You have the right to receive a copy of your health care information that we maintain, with some limited exceptions. You may request access to your health care information in writing and you may request a copy of your health care information in electronic format. You have the right to request that your health care information be sent to any person or entity. Our Medical Records department can help you obtain a copy of your medical records. To start the process, you may use the Authorization to Use/Disclose Health Care Information Form.

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) chemical dependency and mental health conditions (if age 13 and older) per Washington State law.

For prompt and secure access to your health information; sign up for MyChart.

- To view test results, medical history, medications, and care instructions at no cost.
- To send message to provider and their care team, view and pay bills, and request prescription refills.

You can mail, fax completed ROI form to the location below:

☐ International District Clinic PO Box 3007 Seattle, WA 98114 Attn: Medical Records Phone: (206) 788-3712 Fax: (206) 962-3297	☐ ICHS Vision Clinic PO Box 3007 Seattle, WA 98114 Phone: (206) 788-3505 Fax: (206) 962-3302	☐ ICHS Legacy House 803 S Lane St Seattle, WA 98104 Phone: (206) 292-5184 Fax: (206) 292-5271
☐ Bellevue Clinic 1050 140th Ave NE Bellevue, WA 98005 Attn: Medical Records Phone: (425) 373-3012 Fax: (425) 259-8639	☐ Holly Park Clinic 3815 S. Othello Street 2nd Fl Seattle, WA 98118 Attn: Medical Records Phone: (206) 788-3541 Fax: (206) 962-3298	☐ Shoreline Clinic 16549 Aurora Ave. N Shoreline, WA 98133 Attn: Medical Records Phone: (206) 533-2612 Fax: (206) 962-3299
☐ Seattle World School Teen Health Center 1700 East Union St Seattle WA 98122 Phone: (206) 332-7160 Fax: (206) 568-7128	☐ Highland Middle School Health Center 15027 NE Bel-Red Rd Bellevue, WA 98007 Phone: (425) 373-3135 Fax: (425) 373-3134	

Fees for Copying Medical Records:

- ❖ There is no cost if copies are to be sent directly by ICHS to your MyChart account and/or a healthcare provider for the purpose of continuing care or transferring care.

- ❖ For copies for personal or personal representative use, there is a reasonable, cost based fees:
  - The first 10 pages: Free
  - Printed: 11-200 pages: $0.40 cents per page, plus applicable sales tax
201 or more pages: $0.12 cents per page, plus applicable sales tax
  - Postage: applicable amount if records are mailed
  - Delivered Electronic or CD: $6.50 flat fee

  You may request copies on paper, CD, or fax. Payment to ICHS is due upon receipt of your copies.

- ❖ For copies for other uses, the current rates set by Washington state law may apply.

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