Authorization to Use/Disclose Health Care Information

Patient Last Name: _____ First Name: _____ Chart label

Date of Birth: _____ Telephone:_____ MRN:_____

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

ICHS Location:	**Person or Organization Name:**
_____	_____
Address: _____	Address: _____
Phone: _____	City/State/Zip: _____
Fax: _____	Phone: _____
	Fax: _____

Dates of Service: From _____ to _____

☐ All Health Records*	☐ OTHER (Please specify): _____
☐ Progress Notes	☐ All ☐ Specify: _____
☐ Labs/Pathology Test Reports	☐ All ☐ Specify: _____
☐ Diagnostic Reports (X-rays, EKG, etc.)	☐ All ☐ Specify: _____
☐ Immunization Records	☐ All ☐ Specify: _____

In the format requested below: (check the appropriate box)	For the following purpose(s):
☐ Paper ☐ CD ☐ Fax ☐ MyChart	☐ Coordination of Care ☐ Transfer of Care
☐ Provide copies of health record	☐ Personal Use ☐ Legal Matter ☐ Insurance
☐ VERBAL COMMUNICATION ONLY of health information	☐ OTHER (specify): _____

Patient Authorization:

* I am specifically authorizing all sensitive information to be released related to testing, diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, genetics, mental health, substance use disorder and for minors ages 13-17, information regarding reproductive health care unless otherwise indicated below to EXCLUDE. (please initial)

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

_____ Sexually Transmitted Disease _____ Mental Health/ treatment _____ Substance Use Disorder

Expiration: This authorization expires one year from the date signed below OR on the date or on event indicated: (please specify)

_____

I 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 declare that all information regarding my relationship to the patient and my representative authority is true and that I am legally authorized to sign this Authorization on behalf of the patient.(**Documentation proof of legal authority may be required to permit use and disclosure of health information).

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: Received _____ ☐ CareLinked ☐ E-Delivered ☐ Mailed ☐ Picked Up _____

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Release of records may take up to 15 business days

ICHS will only process a disclosure request upon a valid, completed, and signed authorization.

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 request a copy of your health care information in paper or electronic format. There may be a reasonable cost based fee charged to cover the cost of copying, mailing, and supplies. You have the right to request that your health care information be sent to any person or entity. There may be a fee associated with this request. You can authorize VERBAL COMMUNICATION of your health care information with designated person(s) involved in your care. You are entitled to receive a copy of this Authorization at the time it is signed.

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

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

Minor: A minor patient's signature is required to release the following information: (1) conditions relating to the minor's reproductive care (2) sexually transmitted diseases (if age 14 and older), (3) substance use disorder and mental health conditions (if age 13 and older) per Washington State law.

Medical Records department can help you obtain a copy of your medical records. To start the process, you can complete, sign, and send the Authorization to Use/Disclose Health Care Information to us by mail or fax.

International District Medical Clinic PO Box 3007 Seattle, WA 98114 Phone: (206) 788-3700 Fax: (206) 962-3297 **ICHS Vision Clinic** 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 **ICHS PACE** Phone: (206) 462-7100 Fax: (206) 962-3301	Holly Park Medical Clinic 3815 S. Othello Street 2nd Fl Seattle, WA 98118 Phone: (206) 788-3500 Fax: (206) 962-3298 **After Hours Clinic** Phone: (206) 584-2586 Fax: (206) 962-3298
Bellevue Medical Clinic 1050 140th Ave NE Bellevue, WA 98005 Phone: (425) 373-3000 Fax: (425) 259-8639	Shoreline Medical Clinic 16549 Aurora Ave. N Shoreline, WA 98133 Phone: (206) 533-2600 Fax: (206) 962-3299	ICHS Primary Care @ ACRS Phone: (206) 788-3700 or (206) 788-3500 ROI Fax: (206) 800-3621
Seattle World School Teen Health Center 1700 East Union St Seattle WA 98122 Phone: (206) 332-7160 Fax: (206) 284-1801	Highland Health Center 15027 NE Bel-Red Rd Bellevue, WA 98007 Phone: (425) 373-3135 Fax: (425) 373-3134	ICHS Mobile Medical Clinic Phone: (206) 533-2614 ROI Fax: (206) 800-3621

ICHS Fees for Copying Medical Records:

- There is no cost if copies are to be sent directly by ICHS to your 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 fee:
  - 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: Fax or CD $6.50 flat fee
- For copies for other uses, the current fee set by Washington State law may apply.

Notice: Payment to ICHS is due upon receipt of your copies .