Authorization to Use/Disclose Health Care Information

ICHS International Community Health Services

1. **Patient Last Name:** _____ 2. **First Name:** _____ Chart label

3. Date of Birth: _____ 4. Phone Number: _____ 5. MRN:

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

7. **International Community Health Services**
Attn: Centralized Medical Records
(For all ICHS clinics, ACRS, mobile van)

3815 S Othello St Ste 200
Seattle, WA 98118
Phone: (206) 788-3577
Fax: (206) 800-3621

8. **Person or Organization Name:**

_____

Address: _____

_____

Phone: _____

Fax/Email: _____

9. **Date (s) of Service: From** _____ **to** _____

☐ All Health Records*
☐ Progress Notes
☐ Labs/Pathology Test Reports
☐ Diagnostic Reports (X-rays, EKG, etc.)
☐ Immunization Records

☐ OTHER (Please specify): _____
☐ All ☐ Specify: _____
☐ All ☐ Specify: _____
☐ All ☐ Specify: _____
☐ All ☐ Specify: _____

10. **In the format requested below:** (check the appropriate box)

☐ Paper ☐ Fax ☐ CD ☐ MyChart ☐ Secure Email ☐ Verbal

11. **For the following purpose(s):**

☐ Continuity of Care ☐ Insurance ☐ Legal ☐ Transfer of Care ☐ Personal ☐ Other (specify): _____

12. **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, or substance use disorder and for patients ages 13-17, information regarding reproductive health cared unless otherwise indicated below to **EXCLUDE:** (please initial)

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

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

13. **EXPIRATION:** This authorization expires one year from the date signed below OR on the date or event indicated: (please specify) _____

14. **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.

15. **Patient (or Legal Representative)** Signature:** _____ 16. **Date:** _____

17. **Print Name:** _____ 18. **Relationship to Patient:** ☐ Self; ☐ Other (specify): _____

19. **Minor Patient Signature**: _____ 20. **Date:** _____

***Note:** Signature of minors aged 13-17 are 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 based upon a valid, completed, and signed authorization.

Patients:
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.

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) substance use disorder and mental health conditions (if age 13 and older) per Washington State law.

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

MyChart: 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

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☐ **ICHS Legacy House** 803 S Lane St Seattle, WA 98104	Phone: (206) 292-5184	Fax: (206) 292-5271
☐ **ICHS Ron Chew HAWC** 939 Golf Dr S Seattle, WA 98144	Phone: (206) 462-7100	Fax: (206) 962-3301
☐ **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: (206) 457-2653

ICHS Fees for Medical Records:

- There is no cost if records are sent by ICHS directly to your healthcare provider for the purpose of continuity of care or transfer of care.
- There is a reasonable cost-based fees for records for personal and/or personal representative use:
  - Printed: First 1-10 pages: Free
    11-200 pages: $0.40 cents per page, plus applicable sales tax
    201 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
- 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.

Rev: 8/2026