

Authorization to Use/Disclose Health Care Information

Patient Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Telephone: _____ Medical Records #: _____

<input type="checkbox"/> International District Clinic Attn: Medical Records PO Box 3007 Seattle, WA 98114 Phone: (206) 788-3712 Fax: (206) 788-3706	I request and authorize ICHS to <input type="checkbox"/> obtain from or <input type="checkbox"/> disclose to (check the appropriate box) the following entities my health care information: Person or Organization: _____ Address: _____ City/State/Zip: _____ Phone: _____ Fax: _____
<input type="checkbox"/> Vision Clinic PO Box 3007 Seattle, WA 98114 Phone: (206) 788-3505 Fax: (206) 788-3509	To <input type="checkbox"/> obtain or <input type="checkbox"/> disclose (check the appropriate box) the following health care information: <input type="checkbox"/> All Health Records* <input type="checkbox"/> Progress Notes <input type="checkbox"/> All <input type="checkbox"/> Specify: _____ <input type="checkbox"/> Labs/Dx Test Reports <input type="checkbox"/> All <input type="checkbox"/> Specify: _____ <input type="checkbox"/> Radiographic/XRays <input type="checkbox"/> All <input type="checkbox"/> Specify: _____ <input type="checkbox"/> Immunization Records <input type="checkbox"/> All <input type="checkbox"/> Specify: _____ <input type="checkbox"/> OTHER (Please specify): _____
<input type="checkbox"/> Holly Park Clinic Attn: Medical Records 3815 S. Othello Street 2 nd Fl Seattle, WA 98118 Phone: (206) 788-3541 Fax: (206) 788-3521	
<input type="checkbox"/> Bellevue Clinic Attn: Medical Records 1050 140 th Ave. NE Bellevue, WA 98005 Phone: (425) 373-3012 Fax: (425) 373-3100	In the format requested below: (check the appropriate box) <input type="checkbox"/> Paper <input type="checkbox"/> CD <input type="checkbox"/> Electronic/Fax <input type="checkbox"/> Provide copies of health records <input type="checkbox"/> Disclose health information verbally.
<input type="checkbox"/> Shoreline Clinic Attn: Medical Records 16549 Aurora Ave. N Shoreline, WA 98133 Phone: (206) 533-2612 Fax: (206) 533-2641	For the following purpose(s): (check the appropriate box or specify the reason for box "other") <input type="checkbox"/> Coordination of Care <input type="checkbox"/> Transfer of Care <input type="checkbox"/> Personal Use <input type="checkbox"/> Legal Matter <input type="checkbox"/> Insurance <input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> Seattle World School Teen Health Center 1700 E Union St Seattle, WA 98122 Phone: (206) 332-7160 Fax: (206) 568-7128	I UNDERSTAND THAT: *Designating, "All Health Records," above, means the disclosure of my health care information will contain any information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, chemical dependency (including drug and alcohol abuse treatment), mental illness, psychiatric treatment, reproductive health care, and genetics <u>unless</u> I have initialed below to EXCLUDE such information: _____ HIV/AIDS diagnosis/treatment/testing _____ Sexually Transmitted Disease _____ Reproductive Health Care & Genetics _____ Drug/Alcohol abuse/treatment _____ Mental Illness or Psychiatric diagnosis/treatment
<input type="checkbox"/> Highland Middle School Health Center 15027 NE Bel-Red Road Bellevue, WA 98007 Phone: (425) 456-6453 Fax: (425) 456-6467	

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. (Documents needed)
- This authorization will expire on the following date or event: _____
- Unless otherwise specified or restricted by applicable law, this authorization will expire six (6) months 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): _____

ICHS Staff Only: Received: _____ Faxed: _____ Mailed: _____ Picked Up: _____ Initial: _____

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.

Where to Send Your Completed Form:

Mail or fax to the location where you received care:

International District Clinic

PO Box 3007
Seattle, WA 98114
Attn: Medical Records
Phone: (206) 788-3712
Fax: (206) 788-3706

Holly Park Clinic

3815 S. Othello Street 2nd Fl
Seattle, WA 98118
Attn: Medical Records
Phone: (206) 788-3541
Fax: (206) 788-3521

Bellevue Clinic

1050 140th Ave NE
Bellevue, WA 98005
Attn: Medical Records
Phone: (425) 373-3012
Fax: (425) 373-3100

Shoreline Clinic

16549 Aurora Ave. N
Shoreline, WA 98133
Attn: Medical Records
Phone: (206) 533-2612
Fax: (206) 533-2641

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 Road
Bellevue, WA 98007
Phone: (425) 456-6453
Fax: (425) 456-6467

Vision Clinic

PO Box 3007
Seattle, WA 98114
Phone: (206) 788-3505
Fax: (206) 788-3509

Fees for Copying Medical Records:

There is no charge if records are to be sent directly by ICHS to a doctor or other healthcare provider for the purpose of continuing or transferring care.

For copies for personal or personal representative use, ICHS charges the following fees:

- The first 10 pages are free
- 11-200 = \$.39 per page, plus applicable sales tax
- 201 or more pages = \$.12 per page, plus applicable sales tax
- The fee for copies on CD is \$6.50 per CD
- Postage: applicable amount if records are mailed

You may request copies on paper, CD, or electronic/fax. When your record is copied and prepared for you, the copies and an invoice will be sent to you. Payment to ICHS is due upon receipt of your copies.