Authorization to Use/Disclose Health Care Information

Patient Last Name: _____ First Name: _____ Chart Label

Date of Birth: _____ Telephone: _____ MRN#: _____

☐ **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**
11650 SE 60th St
Bellevue, WA 98006
Phone: (425) 456-6453
Fax: (425) 456-6467

I request and authorize ICHS to ☐ **obtain from** or ☐ **disclose to** (*check the appropriate box*) the following entities my health care information:

Person or Organization: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

To ☐ **obtain or** ☐ **disclose** (*check the appropriate box*) the following health care information:

☐ 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 ☐Electronic/Fax

☐ Provide copies of health records ☐Disclose health information verbally.

For the following purpose(s): *(check the appropriate box or specify the reason for box "other")*

☐ 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 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 unless 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

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) 962-3297	☐ **Holly Park Clinic** 3815 S. Othello Street 2nd Fl Seattle, WA 98118 Attn: Medical Records Phone: (206) 788-3541 Fax: (206) 962-3298
☐ **Bellevue Clinic** 1050 140th Ave NE Bellevue, WA 98005 Attn: Medical Records Phone: (425) 373-3012 Fax: (425) 259-8639	☑ **Shoreline Clinic** 16549 Aurora Ave. N Shoreline, WA 98133 Attn: Medical Records Phone: (206) 533-2612 Fax: (206) 962-3299
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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.