

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION – LEGAL
Public Health is not obligated to honor this request unless all portions are completed

The undersigned authorizes:
 Outside Agency (give complete name & address) _____ or Public Health Sites _____

To release the records of: _____

 Client Phone # _____ Date of Birth _____

Records will be released to:

 Phone Number _____ Person & Institution Affiliation _____
 Fax Number (Optional) _____ Street Address _____ City/State/Zip _____

List requested dates here: _____
 If no date given: the last 2 years of data will be released; if a correctional health services request, the last incarceration information will be released.

For the purpose of: medical/dental legal personal other _____

Records Requested: (Photo identification may be required to verify identity _____)
 Clinic or Care Coordination Records WIC Records Head Start (forms *only*)
 Immunization Records Billing Records Dental X-Rays (film *only*)
 Verbal Communication KC MEO Records
 Other (describe) _____
 KC Medic One: Location of Response _____
 Date and time of response _____

I understand that my records may contain information regarding the testing, diagnosis, and/or treatment of HIV (AIDS Virus), positive sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment.

When checked, this authorization Excludes release of the following information:
 Drug or alcohol abuse diagnosis or treatment HIV (AIDS) testing/treatment
 Confirmed STD test results and/or treatment Psychiatric

This authorization expires (insert date or event, invalid if left blank) _____
 Is the receiver an employer or financial institution? (If yes, this will expire in 90 days) Yes No


Client/Guardian Signature _____ Relationship to Patient _____ Date _____

Interpreter _____ Date _____

Your rights under federal and state law:

You have the right to receive your response to this request within 15 business days. You may revoke this authorization at any time by sending a written revocation. If Public Health has acted on this authorization before receipt of your revocation, we cannot be held liable. Public Health may not refuse treatment to you or the person under your guardianship if you do not sign this form. You are entitled to a copy of this form. When Public Health discloses this information, it can be subject to re-disclosure by the recipient and is no longer protected by Public Health.

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Public Health 
 Seattle & King County

Compliance Office
 Public Health - Seattle & King County
 401 Fifth Avenue, Suite 900
 Seattle, WA 98104-1818
 Phone: 206-205-5975
 Fax: 206-205-3945

Client Name: _____
 HR #: _____
 D.O.B.: _____

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 Distribution: White - Health Records

For internal Use Only – ROI REQUEST:

Response to requestor needed by this date: _____

Send to Compliance Office by this date: _____ (Check N/A if not applicable)

Records Checklist – pre Provider review by Records staff Check: Yes No N/A

Responses:

Signature compared and are valid

Authorization valid & if not, explain why this was not returned to requestor: _____

No restriction on release requested by client (check chart documents)

Does each page have a client name and HR #?

Request is for Site documents only

Immune records attached

Off-site dental attached

X-rays attached

Records Center document attached

CIM records attached

Request for multiple sites – please expedite

Clinical Review & Instructions:

Prep Instructions Have pages been redacted? Check: Yes No

Clipped documents or

Progress notes

Entire record

Med. List

Visit notes

Lab results

Do not send, reason: _____

Other comments: _____

Includes STD, HIV, Mental Health, HIV/AIDS re-disclosure notice with records

Denied, reason: _____

Need a different form (Coordination of Care, valid Authorization)

Other: _____

Provider/Reviewer Signature & Title

Date Reviewed

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