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 <u>Excludes</u> 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, <u>invalid if left blank</u>) _____

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

<u>Your rights under federal and state law:</u>

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.

Compliance Office
Public Health – Seattle & King County
401 Fifth Avenue, Suite 1220 Phone: 206-205-9700
Seattle, WA 98104-1818 Fax: 206-205-3945

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
  - ☐ X-rays attached
  - ☐ CIM records attached
  - ☐ Off-site dental attached
  - ☐ Records Center document attached
- ☐ Request for multiple sites – please expedite

Clinical Review & Instructions:

Prep Instructions Have pages been redacted? Check: ☐ *Yes* ☐ *No*

- ☐ Clipped documents or
- ☐ Entire record
- ☐ Visit notes
- ☐ Progress notes
- ☐ Med. List
- ☐ 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

AUTHORIZATION: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION - Legal

Public Health
Seattle & King County

Client Name: _____

HR #: _____

D.O.B.: _____

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Public Health – Seattle & King County
401 Fifth Avenue, Suite 1220
Seattle, WA 98104-1818
Phone: 206-205-9700
Fax: 206-205-3945

Distribution: White – Health Records