AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR CLINIC AND FIELD RECORDS

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:

Person & Institution Affiliation ______

Street Address ______ City/State/Zip ______

Phone Number ______ Fax Number (Optional) ______

List requested dates here: ______
(If no date given: the last 2 years of data 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*)
- Other (describe) ______

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

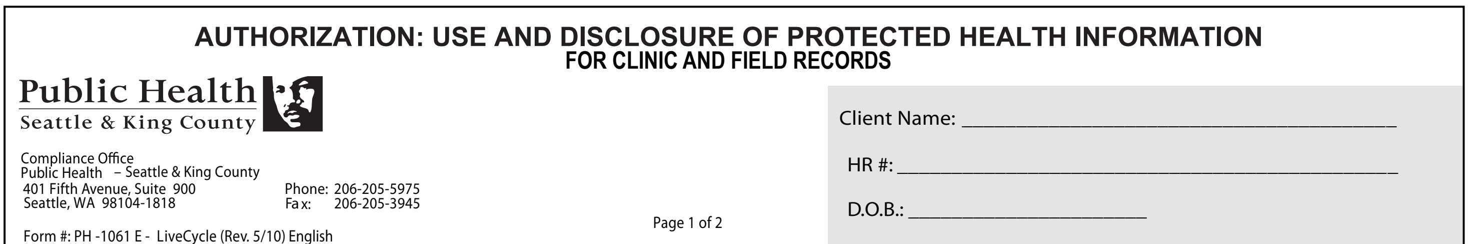
Client/Guardian Signature ______ Relationship to Patient ______ Date ______

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.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION - for Clinic and Field Records


AUTHORIZATION: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
FOR CLINIC AND FIELD RECORDS

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.: ______

Form #: PH -1061 E - LiveCycle (Rev. 5/10) English

PO 1-15-05-020

Distribution: White – Health Records

For internal Use Only – ROI REQUEST:

Response to requestor needed by this date: ____

Send to Compliance Office by this date: __________________________ (*enter 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

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