



### Authorization to Release Patient Health Information

Pacific Medical Centers will only process valid and complete Authorization forms.

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Contact Telephone (\_\_\_\_) \_\_\_\_\_

#### I authorize Pacific Medical Centers to release information to:

Organization/Individual \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_ Fax # (\_\_\_\_) \_\_\_\_\_

#### PURPOSE OF DISCLOSURE:

Continuing Care  Legal  Insurance  Patient Request for Patient Use  Transferring Care  Other \_\_\_\_\_

#### INFORMATION TO BE RELEASED:

Dates of service for records requested: from \_\_\_\_\_ to \_\_\_\_\_

Clinic Notes  Lab/Pathology Reports  Radiology Reports  Other \_\_\_\_\_

NOTE: There may be a charge for copying the patient record, please see the reverse side.

#### PLEASE CHECK ONE

PMC  is/  is not authorized to release any health care information relating to such diagnosis, testing or treatment relating to: sexually transmitted diseases, HIV/AIDS, psychiatric disorders/mental health, or treatment of drug and/or alcohol abuse.

#### I UNDERSTAND THAT:

- Authorizing the disclosure of the health information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I can cancel this authorization at any time by writing to the Health Information Management Department. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

#### PARENTAL REQUEST FOR CHILD'S MEDICAL RECORDS (for patients 17 and under, except noted below)

I hereby declare under penalty of perjury, that I am the natural or adoptive parent or legal guardian of said child and there is no court order restricting or prohibiting my access to such medical records.

Parent or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

**MINORS**—In compliance with Washington state law, minors must sign the request themselves if the information requested includes: 1) treatment for alcohol and/or drug abuse or mental health conditions (13 and older) or 2) conditions relating to the minor's reproductive care including, but not limited to, birth control, pregnancy related services and STDs. (14 and older)

\_\_\_\_\_  
Date Signature of patient or legal representative Relationship, if not patient (Please initial page 2)

This authorization will expire in 1 (one) year unless otherwise specified. "Non-emergency" release of records may take up to 15 working days. "Emergency" status applies only to records released directly to another healthcare provider for urgent patient care & will be given priority processing.

**Mail Completed form to:** Pacific Medical Centers  
Attn: Release of Information, HIM Dept  
1200 12th Ave S  
Seattle, WA 98144

**Or you may fax the completed form to: 206-621-4235 Attn: ROI**

**Questions?? 206-621-4150  
or email [roi@pacmed.org](mailto:roi@pacmed.org)**

**Release of records may take up to 15 working days.  
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*If you would like to get your records from another facility or provider, please contact that facility or provider.*

**Where to send the completed form:**

- If you complete this form at PMC, you may give it to a clinic staff member to send to the Health Information Department.
- If you are completing this form at home, you may mail or fax the form to:  
Pacific Medical Center Health Information Department  
Attn: Beacon Hill ROI  
1200 12<sup>th</sup> Ave. S.  
Seattle, WA 98144  
**or fax to 206-621-4235**

**Where to call with questions:**

- To check status on a request, please call 206-621-4150

**Fee for copying medical records**

If you are requesting a copy for your personal use, a fee will be charged (see fee schedule below). Charges for the copies are in compliance with the Washington Administrative Code (WAC 246-08-400)

0-10 pages, no charge

If more than 10 pages, 0-30 pages, \$1.02 per page

Over 30 pages, \$0.78 per page

Initials \_\_\_\_\_

**MENTAL HEALTH INFORMATION**

State law (RCW 71.05.39) prohibits any further disclosure of mental health information without specific written consent of the person to whom the information pertains, or the parent or legal guardian of a minor child to whom it pertains, unless otherwise permitted by state law. A general authorization to release information is NOT sufficient for this purpose.

**CONSENT OF MINOR (RCW 70.96A.230, RCW 70.96A.235, RCW 70.96A.095)**

A minor patient's signature is required to release the following information: 1) Conditions relating to reproductive care including, but not limited to, birth control and pregnancy-related services and sexually transmitted diseases, including HIV/AIDS (age 14 and older) and 2) substance abuse diagnosis or treatment and mental health conditions (age 13 and older)

**PROHIBITION ON RE-DISCLOSURE OF HEALTH INFORMATION**

Federal and state laws prohibit re-disclosure of information concerning drugs and alcohol abuse treatment, sexually transmitted disease information or mental health information without the specific written consent of the person to whom the information pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.