Authorization for Use and Disclosure of Protected Health Information

Purpose: This form is used for an individual's request to disclose or restrict use of his/her protected health information.

I authorize (Provider): ______________________ Provider Phone #: ______________

Medical Office: ______________________ Provider Fax #: ______________

Address: ______________________ City, State, Zip: ______________

to release health/medical record information of: ______________________

Patient's Full Name Previous Name Date of Birth

This information is to be released to:

Name: ______________________ Phone #: ______________

Address: ______________________ Fax #: ______________

____

for the purpose of:

- ☐ Permanent transfer to new provider: ______________________
- ☐ My health consultation with: ______________________
- ☐ Research study or marketing purposes requested by: ______________________
- ☐ Other: ______________________

You may use or disclose the following health care information (check all that apply):

- ☐ **Complete Medical Record Abstract** (includes office notes, radiology and lab reports, consult notes and inpatient reports for the last three years)
- ☐ My health information **relating only to the following treatment or condition**: ______________________
- ☐ My health information **only for the following date(s)**: ______________________
- ☐ Other: ______________________

You may use or disclose health information regarding testing, diagnosis, and treatment for (check all that apply):

- ☐ HIV (AIDS virus)
- ☐ Sexually transmitted diseases
- ☐ Psychiatric disorders/mental health
- ☐ Drug and/or alcohol use

This authorization ends: ☐ on the following date:__________or, ☐ when the following event occurs:______________.

If neither of the above is checked, this request will expire 90 days from the date of signature.

A fee for the costs of processing this request may be charged (see "Photocopy Charges for Medical Records"). I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization to take part in a research study or to receive health care when the purpose is to create health information for a third party. I may revoke this authorization in writing at any time by submitting to the Providence Physician Services (PPS) clinic or to the PPS Privacy Officer at 101 W. Eighth Ave., Spokane, WA 99204. I understand the revocation will not apply to any previously released information and would not affect any actions already taken based on this authorization. I understand the revocation may not apply if its purpose was to obtain insurance or when the law provides my insurer with the right to contest a claim under my policy. Once PPS discloses health information, I understand the person or organization that receives it may re-disclose it and privacy laws may no longer protect it. I understand PPS will provide me with a copy of this signed authorization.

Signature of Patient or Legal Representative:______________________**Date:**__________

If signature is by a legal representative of the patient, please complete the following and attach legal documentation:

Legal representative's name (please print): ______________________

Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Power of Attorney for Healthcare ☐Other __________

FOR OFFICE USE ONLY

DATE REQUEST FILLED: ______________ BY: ______________ FEE COLLECTED: $__________

IDENTIFICATION PRESENTED: ______________ COPY OF AUTHORIZATION PROVIDED TO PATIENT:__________

Notice to Patients
Photocopy Charges for Medical Records

Our clinic is happy to provide copies of your medical records per your request. Washington State regulations RCW 70.02 and WAC 246-08-400 allow medical providers to charge fees for searching and duplicating medical records. These fees, which cover the cost of labor and supplies, are adjusted every two years by the Department of Health. HIPAA regulation Section 164.524 (c)(4) also allows for these services to be charged to the patient. In addition, a covered entity may charge 1) for postage when the individual has requested that the protected health information be mailed and, 2) for preparation of a summary or explanation of the protected health information if requested by the individual.

Therefore, please note you will be charged the following fees:

Service	Cost
10 or fewer pages	No Charge
Pages 11 and greater	$0.38/page
Postage	Actual cost

If you have any questions regarding the process of your request, please contact your physician's Office Manager.