North Olympic Healthcare NETWORK

RELEASE OF INFORMATION REQUEST

240 W. Front Street
Port Angeles, WA 98362
Fax: (360) 412-6494

[PLACE LABEL HERE]

PATIENT INFORMATION:

Patient Name (please print): _____ Date of Birth: _____

SEND INFORMATION TO: (please be specific)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

INFORMATION TO BE RELEASED FROM: (please be specific)

Provider Name/Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

PURPOSE OF DISCLOSURE:

❑ Further Medical Care ❑ Attorney ❑ School ❑ Research

❑ Personal Use ❑ Insurance ❑ Disability ❑ Other _____ (must complete)

INFORMATION TO BE DISCLOSED:

❑ Only information related to (specify): _____

❑ Only the period of events from _____ to _____

❑ Entire Record (last two years)

SENSITIVE INFORMATION TO BE INCLUDED: (check all that apply)

❑ Substance Use Treatment/Referral ❑ HIV/AIDS-related treatment

❑ Sexually Transmitted Diseases ❑ Mental Health (other than Psychotherapy Notes)

❑ Psychotherapy Notes ONLY (By checking this box, I am waiving any psychotherapist-patient privilege.)

CONSENT TO DISCLOSE

I understand that I may revoke this authorization in writing submitted at any time except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate **one year** from the date of my signature unless a different expiration date or expiration event is specified. *This authorization will end _____. (specify date)*

I understand that North Olympic Healthcare Network will not condition treatment or eligibility of care on my providing this authorization.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

A minor patient's signature (13-17 years old) is required to release mental health, alcohol/drug information.

A minor patient's signature (14-17 years old) is required to release information regarding pregnancy, terminations, sterilization, or sexually transmitted diseases.

_____ _____ _____

Signature of patient or representative **Relationship to patient** **Date**

❑ *Please check box if this patient signature is a minor 13-17 years old.*