☐ ABERDEEN	☐ EVERSON	☐ MILTON	☐ ROCHESTER	☐ TUKWILA
☐ ANACORTES	☐ EVERETT	☐ MONROE	☐ SEATTLE	☐ UNIVERSITY PLACE
☐ BATTLE GROUND	☐ FIFE	☐ MT. VERNON	☐ SKAGIT VALLEY	☐ VANCOUVER MEDICAL
☐ BELLEVUE	☐ GIG HARBOR	☐ OAK HARBOR	☐ TACOMA	☐ VANCOUVER FOURTH PLAIN
☐ BELLINGHAM	☐ KENT	☐ OCEAN SHORES	☐ TENINO	☐ VANCOUVER SALMON CREEK
☐ BURIEN	☐ LACEY	☐ OLYMPIA	☐ TILLICUM	☐ VANCOUVER WOMAN'S CLINIC
☐ CONCRETE	☐ LAKEWOOD	☐ PASCO	☐ THURSTON CO.WI	☐ WHITE CENTER
☐ DES MOINES	☐ LYNNWOOD	☐ PUYALLUP	☐ TUMWATER	☐ YELM
☐ ELMA	☐ MARYSVILLE			

Sea Mar
Community Health Centers
Clínica de la Comunidad

Health Information Management Department

Authorization to Use or Disclose Protected Health Information

PATIENT ID: Records Delivered by: ☐ FAX ☐ CD ☐ Mail ☐ In-Clinic ☐ Verbal Disclosure

PATIENT INFORMATION	Name: ______ DOB: ______ Address: ______ City: ______ State: ______ Zip: ______ Primary Phone ______ Sea Mar Primary Care Provider: ______
From *Please list the specific hospital or clinic.*	Name: ______ Address: ______ City: ______ State: ______ Zip: ______ Phone: ______ Fax: ______
To *Please list where you would like the records sent.*	Name: ______ Address: ______ City: ______ State: ______ Zip: ______ Phone: ______ Fax: ______
Information to be released *Please initial all that apply*	___ Recent summary of care including Medication List, Problem List, Last three H&P/Progress Notes, Recent Imaging, Immunizations, Last Pap Smear, Last Mammogram, Last Colonoscopy, EKG, Recent lab work ___Health care information in my medical record for the following dates/treatments: ______ ___ Other indicated records: ______ Dental Records/X-Rays only: ______ ___ Lab results (please specify lab tests or dates):______
Specially Protected Information ***Unless initialed these records will not be sent***	___HIV/Aids ___ Sexually Transmitted Diseases ___ Substance Abuse ___ Mental Health/Psychiatric Conditions Title 42 of the United States code, stipulates this information cannot be released without Authorization by law.
Purpose of the release	☐ At my request ☐ Transfer of Care ☐ Other (Please specify):______
Expiration	**Authorization Expires (Required Field, Must Be A Date Or An Event):** ☐ When revoked in writing ☐ ______ Days/Month ☐ When Records Received ☐ When the Following Occurs: ______
Patient Rights	I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). I understand I have to sign this authorization form to take part in a research study or to receive health care when the purpose is to create health care information for a third party. I understand I may revoke this authorization in writing at any time. If I do so, this will not affect any actions already taken by the disclosing health care entity in accordance with the authorization. I understand that once health care information is disclosed, if the person or organization that receives it is not covered by federal or state patient privacy laws, the health care information may be re-disclosed without protection of privacy laws.
Signature	I have read this authorization, and I understand it. ______ ______ Signature of patient or legal representative Date ______ ______ Printed name is signed by party other than patient Relation to patient if not self

Staff Use Only-Please print name

Received by (assisted patient with form) ______

Faxed by (form faxed to destination) ______

□ **I have completed all actions. This form requires scanning into patient chart only (staff initials) ______**