AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Olympic Medical Physicians
433 E. 8th St. • Port Angeles, WA 98362 • (360) 457-8578
Fax: (360) 457-4841

PATIENT INFORMATION

Patient Name (printed):_____ Previous Name(s):_____

Date of Birth:_____ Daytime Telephone Number:_____

SEND INFORMATION TO: (please be specific)

Name: **Peninsula Children's Clinic**

Address: **433 E. 8th St.**

City: **Port Angeles** State: **WA** Zip: **98362**

Phone #: **(360) 457-8578** Fax #: **(360) 457-4841**

INFORMATION TO BE RELEASED FROM: (please be specific)

Provider Name/Organization:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone #:_____ Fax #:_____

PURPOSE OF DISCLOSURE

❑ Transfer of Care ❑ Self ❑ Specialist ❑ Other _____(must complete)

INFORMATION TO BE DISCLOSED

❑ Medical Records from last two years

❑ Limited Health Information or Documentation Dates of Service:_____

❑ Complete Medical Chart Contents

❑ Other_____ Expiration Date (or event)_____

FORMAT ❑ Paper ❑ Electronic (MyChart)

CONSENT TO DISCLOSE

If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient. This form may be revoked at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization. We will not condition treatment on the completion of the authorization. Also, please be aware that once we disclose this information per your instructions the information is subject to re-disclosure and may no longer be protected by the HIPAA of 1996.

Date	Signature of patient or representative	Relationship to patient

DISCLOSURES REQUIRING SPECIAL CONSENT

My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for (Please initial beside the specific information to disclose):

_____ HIV/AIDS Virus _____ Mental Health/Psychiatric Disorders

_____ Sexually Transmitted Diseases _____ Drug, Alcohol Abuse/Treatment

Date	Signature of patient or representative	Relationship to patient

FOR FACILITY USE ONLY

Date Received:_____ Date Information Released:_____ Chart #:_____

Person/Department Sending Records: _____

❑ Faxed ❑ Mailed ❑ MyChart ❑ Picked Up:_____ ❑ Other:_____