AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This Authorization is made pursuant to the Privacy Rule of the Federal Health Insurance Portability and Accountability Act and Washington's Uniform Health Care Information Act.

Patient Information:

_____

(PRINT name of Patient) DOB Former name(s)

_____

Telephone number Address

Information to be released from:

City of Bremerton Fire Department

Name of designated facility or provider

911 Park Avenue, Bremerton, WA 98337 360-473-5380

Address Phone number

I request and authorize the above named facility or provider to release my health care information to:

_____

Name of designated recipient(s)

_____

Address City, State, Zip

_____

Phone number Fax Email

Format of Information:

My health care information may be released/provided in any form, including verbally, by computer data transfer, e-mail, mail, fax, or hand delivery.

Information to be Released:

☐ The most recent 2 years of pertinent information (charts, notes, labs, x-rays, and special tests)
☐ All Medical Records
☐ All Medical Billing Records
☐ Specific Information (please specify): _____

_____

Limit to Records Disclosed:

I want to limit the records to be disclosed as follows (by date, type of record, etc.): _____

_____

Purpose for which disclosure is being made (please check one of the following):

☐ Attorney ☐ Insurance ☐ Doctor ☐ Personal

☐ Other: _____

_____

Additional Authorization for special records:
I understand that my express consent is required to release any health care information relating to testing/diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you ☐ are ☐ are not specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

Term of Authorization:
This Authorization is valid for ___ days after the date of my signature, unless otherwise another date is specified here: _____.

My Rights:
I understand I do not have to sign this authorization in order to obtain health care (if I am a Bremerton Fire Department patient), or the benefits of treatment, payment or enrollment (if I am a City of Bremerton employee).

I may revoke this authorization in writing at any time, but that will not affect information already produced. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under privacy laws.

I agree that a scanned or copied version of this form is valid to give my permission to disclose records.

Reasonable Fee:
State law provides that a health care provider may charge a reasonable fee to provide copies of its records.

_____ _____
Signature of Patient or Patient's Authorized Representative* Date Signed

*If I am not the person who is the subject of the records, I am authorized to sign because I am the subject's: (*attach proof of authority*)
☐ Attorney ☐ Parent of minor ☐ Legal guardian ☐ Personal representative
☐ Other: _____

Notice to those receiving information pursuant to this authorization: If these records contain information about HIV, STDs, or alcohol or drug abuse, you may not further disclose that information under federal and state law without specific permission of the subject and meeting specific legal requirements.