Authorization To Release/Obtain/Exchange Patient Health Information

Patient

Patient Name: _____ Date of Birth: _____/_____/_____
(Legal Name) Last First Middle Month Day Year

Other Names Used: _____ Medical Record Number: _____
(if applicable) (if known)

Release

I authorize Seattle Children's Hospital to: ☐ Release To ☐ Obtain From ☐ Exchange With (Verbal Information Only)

Organization/Recipient/Person _____ Attn: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone #:(____)_____ Fax #:(____)_____ Email: _____
(required for CD and electronic delivery)

Delivery/Purpose

Paper copies will be mailed to the recipient unless another format is checked below:

☐ CD (compact disc) ☐ Secure Email (patient/family only)

Please indicate the purpose(s) of your request:

☐ Continuing Care ☐ Transfer of Care ☐ Personal Use ☐ Legal ☐ Insurance ☐ Disability ☐ School

☐ Other (please provide details): _____

Information

Records for Dates:

From **To**

_____ -- _____
Month/Year **Month/Year**

If no date is specified, only the most recent clinical documentation will be released.

☐ Inpatient Hospital Stay
☐ Outpatient Clinic/Emergency Department
☐ Lab & Radiology Reports
☐ Operative/Procedure Notes
☐ Radiology Images (on CD)
☐ Billing Records

☐ Psychiatric Summary/Care Plan
☐ Educational Records
☐ Odessa Brown Records
☐ Other (please provide details)

_____

Notices

I understand that:

- Signing this release of health information is voluntary; I do not need to sign this form for treatment or payment.
- Any disclosure of information has the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.
- I can cancel this authorization at any time by informing the Health Information Integrity department in writing. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.

Signatures

This authorization expires **one (1) year** from the date signed **unless** another date or event is indicated here: _____

Exception: if patient information is to be released to an employer or financial institution, this authorization is only valid for 90 days from the date signed.

Minors (age 13-17) - A minor patient's signature is required below to release the following information: 1) conditions related to reproductive care including, but not limited to, birth control, pregnancy-related services and sexually transmitted infections including HIV/AIDS (age 14 or older) 2) mental health conditions (age 13 and older) 3) drug and alcohol abuse diagnosis or treatment (age 13 and older) (This information is subject to Federal Regulation 42 CFR Part 2 - See reverse for more information).

I specifically authorize Seattle Children's to release health information checked below:

☐ Reproductive Care ☐ Sexually Transmitted Infections (incl. HIV/AIDS) ☐ Mental Health ☐ Drug/Alcohol Abuse

_____ _____ _____
Signature of Minor Patient (Legal Name of Patient) | Printed Name | Date Signed

_____ _____ _____
Signature of Patient/Legal Representative (Legal Representative) | Printed Name | Relationship to Patient

(_____) _____ _____
Phone Number | Date Signed

Staff

Have the records been released to the requestor? ❑ Yes ❑ No Staff Name: _____ Clinic/Unit _____

Please forward the completed authorization to the Health Information Integrity department (818-HI)

Seattle Children's
HOSPITAL · RESEARCH · FOUNDATION

PO BOX 5371, 818-HI
SEATTLE, WA 98145-5005
PHONE: 206-987-2173 FAX: 206-985-3252

44036

PATIENT LABEL

AUTHORIZATION TO RELEASE/OBTAIN/EXCHANGE PATIENT HEALTH INFORMATION

Instructions for completing the Authorization to Release/Obtain/Exchange Patient Health Information form

Purpose: To request that Seattle Children's Hospital provides health information to a recipient outside of Children's, requests that outside information be sent to our organization, or to exchange verbal information about your child.

Instructions to Staff:

- This authorization form does not need to be completed when clinical or unit staff provides the information directly to the legal representative or current outside provider. (If processing the request please complete the "Staff" section on the form before sending to HII).
- For other recipients, or when clinic is not able to provide the information, send form to HII at 818-HI, but first:
  - Check for form completion and write neatly:
    - Patient Information
    - Recipient's name and complete address
    - Clear information about what is being requested to release (for example specific date ranges or record type)
    - Signature of patient/legal representative and contact information for the requestor
    - Signature (when required for specific consent-see additional information below)
- If requested, give parent/legal representative directions to HII department for hand delivery of form.

Instructions for Patient/Legal Representative:

- **Completing the form:**
  - Check for form completion and write neatly:
    - Patient Information
    - Recipient Information
    - Specific information to be released (for example dates ranges, record type, etc.). If no date range is indicated, an abstract of records will be sent (most recent clinical documentation).
    - Signature of legal representative
    - Signature of patient (minor's signature is required to give specific consent-see additional information below)
- **Where to send the form:**
  - If you complete this form at Children's, give it to a clinic or inpatient unit staff member to send to the HII Department.
  - If you are completing this form outside of Children's, you may mail or fax the form to Seattle Children's Health Information Integrity department (see address and fax number on front of form). You can also email the completed form to healthinformation@seattlechildrens.org
- **Where to call with questions:**
  - Health Information Integrity: 206-987-2173
  - Radiology Image Library: 206-987-2731, Option 3

Additional Information

CONSENT OF MINOR

A minor patient's signature is required in order to release the following information: 1) conditions related to reproductive care including, but not limited to, birth control, pregnancy-related services and sexually transmitted infections, including HIV/AIDS (age 14 and older) 2) drug and alcohol abuse diagnosis and treatment (age 13 and older) 3) mental health conditions (age 13 and older).

FEE FOR COPYING MEDICAL RECORDS

There may be a fee for copying medical records. If a fee does apply, you will be contacted to approve the fee before HII completes your request.

PROHIBITION ON REDISCLOSURE OF HEALTH INFORMATION

- Federal and State laws prohibit redisclosure of information concerning sexually transmitted infections or mental health conditions without the specific written consent of the person to whom the information pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.
- Drug and alcohol abuse and treatment records are protected by Federal Confidentiality rules (42 CFR Part 2). The federal rules prohibit the recipient of this information from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

FORMAT TO RECEIVE MEDICAL RECORDS

- **Compact Disc (CD):** Electronic records (with the exception of radiology images) will be password protected. To have the password emailed to you, please provide your email address on the authorization form. If no email address is provided, the password will be mailed separately to the postal address listed on the authorization form.
- **Secure Email:** You must provide an email address to receive medical records in this format. For more information on how to open an encrypted message, please visit: https://www.seattlechildrens.org/healthcare-professionals/gateway/clinical-resources/opening-encrypted-messages-from-seattle-childrens/
- **MyChart:** You may receive records via MyChart account by submitting a request through MyChart.

PATIENT LABEL