Patient Name *(Please print full name)*: _____ **Date of Birth:** _____

Address: _____ **Age:** _____

Phone #: _____

❑ Paper Copy ❑ Electronic Copy (CD-ROM) ❑ Verbal health care information can be given to: _____
(Full Name & Date of Birth)

❑ Electronic Delivery: If you would like to receive your records electronically via our secure Patient Portal please provide your email address: _____. You will be notified by email when your records are ready to be downloaded. For further information, please go to: http://patientportal.iodincorporated.com/MultiCare (Charges may apply for records copied)

Purpose of Disclosure

❑ Further Medical Care ❑ Personal ❑ Billing ❑ Insurance Eligibility/Benefits

❑ Legal Investigation/Action ❑ Other: _____

Information may be disclosed by: (select a box)

❑ **MultiCare Health System** (*Unless otherwise specified, we will provide records from all MultiCare locations* of service applicable to the date(s) of service noted. Please specify if you would like records located to a specific MultiCare hospital, clinic, or other site-of-service).

--OR--

❑ Provider, Name/Facility: _____

Address: _____ Phone: _____ Fax: _____

Information may be disclosed to:

Name/Facility: _____

Phone: _____ Fax: _____

Address: _____

Information to be disclosed:

Dates of Service and/or Conditions Treated: _____

Select type(s) of information that may be disclosed:

Routine Medical Records Sets --------OR--------

❑ **Clinic Records** (Includes: Office Visit, Laboratory, Radiology, Medication Record, Immunization Record)

❑ **Hospital Records** (Includes: History and Physical, Discharge Summary, Operative Report, Consultations, Emergency, Laboratory, Radiology)

❑ **Billing Records**

❑ **Copies of Images and Films**

Specific Medical records Documents Only

❑ Discharge Summary/Note
❑ History and Physical
❑ Operative Report
❑ Radiology Report
❑ Laboratory Report
❑ Pathology Report
❑ Emergency Report
❑ Immunization Record
❑ Nursing Notes
❑ Medication Notes
❑ Progress Notes/Clinic Notes
❑ Rehab Therapy (PT/OT/ST
❑ Other (please specify): _____

I authorize the release of the below information: (initial all that apply)

_____ HIV (AIDS virus) * see reverse _____ Sexually Transmitted diseases _____ Genetic Information and Indicators

_____ Psychiatric disorder or mental health _____ Drug or alcohol abuse

**** * * NOTE: If this section is not completed, records of this type (if they exist), will not be released. * * ****

***** If the records requested above will result in any charges, I understand I will be contacted with an estimate of those charges before the records are produced. MultiCare's charges for release of information vary depending upon the nature and extent of the records requested. For more information, please go to http://www.multicare.org/medical-records***

This Authorization Expires in 90 days: (Unless a date or event is specified here): Date/Event: _____

_____ _____ *Legal Authority: _____

Signature of Patient/Representative **Date/Time** **(If signed by person other than the patient, print name and identify relationship.)*

Patient Identification - Write in or attach patient label

Name:

MRN #:

CSN #:

Age / Sex:

CONSENT TO USE OR RELEASE MY HEALTH CARE INFORMATION

MultiCare

87-8455-5e A (Rev. 2/16)

MY RIGHTS

Once MultiCare discloses your health information, the recipient may re-disclose your information and privacy laws may no longer protect your information. Federal and state laws forbid reporting of information about alcohol abuse treatment, sexually transmitted diseases, or mental health issues without written consent of the patient, or by law.

I understand I can withdraw this consent form at any time. Withdraw requests must be submitted in writing to Health Information Management Department, P.O. Box 5299, Mailstop 1002-1-HIM, Tacoma, WA 98405, Attention HIM/ROI. Withdrawing this consent would not affect any actions or reports already made by MultiCare Health System and will not affect MultiCare's usage of the information to bill for services.

I understand I do not have to sign this authorization in order to get healthcare benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form:

- To take part in research study, or
- To receive health care when the purpose is to create health care information for a third party.

I understand I may be charged a fee for the copies. Cost information can be obtained from the Health Information Management Department on 253.403.2433.

MULTICARE USE ONLY

❑ **This request was completed and Medical Records were given to the patient at the clinic or hospital. Please scan this release into Epic.**

DRUG AND ALCOHOL ABUSE INFORMATION

Federal law (42 CFR Part 2) forbids any release of this information except with written consent of the person whose information it is. The parent or legal guardian of the minor child may consent unless the patient is 13 or older. In that case, the signature of the patient is required. A general authorization for the release of information is NOT enough for this purpose. The Federal rules limit any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

MENTAL ILLNESS INFORMATION

State law forbids any disclosure of mental health information without specific written consent of the person whose information it is. The parent or legal guardian of a minor child may consent unless the minor patient is 13 or older. In that case, signature of the patient is required. A general authorization to release information is NOT enough for this purpose. (See RCW 71.05.390)

SEXUALLY TRANSMITTED DISEASE INFORMATION (Includes HIV/AIDS)

State law forbids any disclosure of this information without specific written consent of the person whose information it is. The parent or legal guardian of the minor child may consent unless the patient is 14 or older. In that case, the signature of the patient is required. A general authorization to release information is NOT enough for this purpose. (See RCW 70.24 and WAC 246-100.)

CONSENT FOR MINOR

A signature of a minor patient is required to release information concerning care for: (1) birth control and pregnancy-related care, (2) sexually transmitted disease information (including HIV/AIDS) if the minor is 14 or older, (3) substance abuse diagnosis or treatment if the minor is 13 or older, and (4) outpatient mental health information if the minor is 13 or older.

PROHIBITION ON REDISCLOSURE OF HEALTH INFORMATION

A general authorization for the release of medical or other information is NOT enough for this purpose. The Federal rules limit any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

GENETIC INFORMATION

Genetic information includes many things, ranging from the results of any genetic testing, to your family's medical history. It also includes information about any genetic disorders or conditions you have or might have, as well as any genetic services you have received, are currently receiving, or have requested to receive. Also included is genetic information about a pregnancy, fetus, or embryo (including if in-vitro fertilization, or other assisted reproductive technology, is used).