NORTHWEST SPOKANE PEDIATRICS
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Authorization to Disclose or Release Health Information

AUTHORIZATION TO DISCLOSE RECORDS OF:

NAME LAST	FIRST	MIDDLE	DATE OF BIRTH

The following information may help in locating records:	FORMER NAMES

PATIENT IDENTIFICATION NUMBER	OTHER IDENTIFICATION NUMBER	DATES OF SERVICE	LOCATION OF SERVICE

DISCLOSE TO:

NAME LAST	FIRST	TITLE

NAME OF OFFICE

ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE NUMBER (INCLUDE AREA CODE)	FAX NUMBER (INCLUDE AREA CODE)	E-MAIL ADDRESS

ADDITIONAL INFO THAT MAY BE HELPFUL

AUTHORIZATION:

SOURCES: I authorize the following information to be released. Information may be provided verbally or by computer data transfer, mail, fax, or hand delivery.

☐ The following information should be disclosed / released (check all that apply):

- ☐ Hospital Records / Reports
- ☐ Surgical Reports
- ☐ Medical History, Examination Reports
- ☐ Treatments or Tests
- ☐ Allergy Records
- ☐ Consultations
- ☐ Immunizations
- ☐ Imaging Reports (X-ray, MRI, CT, etc)
- ☐ Prescribed Medications
- ☐ Sports Physicals
- ☐ Well Care Visits
- ☐ Sick Visits
- ☐ Other: _____

☐ All parts of the patients health record that are on file

SPECIAL CONSENT RECORDS: I authorize the following records to be disclosed: (check all that apply)

- ☐ HIV /AIDS
- ☐ Drug or Alcohol Abuse
- ☐ Mental Health or Illness
- ☐ Reproductive Care
- ☐ Sexually Transmitted Diseases

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

PLEASE NOTE: If your health records include any of the above information, you must also complete to allow disclosure of these records. Minors 13 and older must also sign to release these.

DISCLOSURE REASON:

- ☐ Further Medical Care
- ☐ Insurance
- ☐ Changing Medical Provider
- ☐ School / Daycare / Camp
- ☐ Legal
- ☐ Other: _____

- This permission is valid for 180 days or ☐ until _____ (date or event, if not checked, will be 180 days).
- I may revoke or withdraw my permission in writing at any time, but that will not affect information already produced.
- I understand that my records may no longer be protected under the laws that apply after they are produced.
- A copy of this form is valid to give my permission to disclose records. There may be a fee to provide copies of our records.

AUTHORIZED BY (SIGNATURE)	DATE SIGNED	TELEPHONE NUMBER (INCLUDE AREA CODE)

PRINT NAME	WITNESS/MINOR (SIGN AND PRINT NAME, IF APPLICABLE)

If I am not the person who is the subject of the records, I am authorized to sign because I am the: (attach proof of authority)
☐ Parent of minor ☐ Legal Guardian ☐ Personal Representative ☐ Other:

Notice to those receiving information: 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.

INSTRUCTIONS FOR COMPLETION OF AUTHORIZATION FORM

Purpose: You should use this form when you want NWSP to be able to disclose confidential information about you to another person (including an attorney, a legislator, or a relative). You may give permission to disclose all confidential records NWSP has about you or you may limit your permission to specific records or parts of the agency. This form will also permit NWSP to discuss your situation verbally with the person you authorize.

Notice to Clients: Most client information NWSP has is confidential and will not be disclosed to others unless you grant permission or if disclosure is allowed by law. After NWSP discloses your confidential information, please be aware that the recipient may not protect your records under the same laws that apply to NWSP. For information on how NWSP health care components covered by HIPAA share protected health information and your privacy rights, please consult the NWSP Notice of Privacy Practices at www.nwspkids.com or ask the person who gave you this form. You may get a copy of this form after it is completed.

Use: You may fill out this form electronically or by hand. Use the tab key on a computer to move between fields. **A separate form must be completed for each child you are requesting records for.** "You" refers to the subject of the records.

Parts of Form:

IDENTIFICATION OF SUBJECT OF RECORDS:

- Name: Provide your full name or the name of the person whose records are requested if you are acting for someone else.
- Date of birth: Please include this information needed to identify you from persons with similar names.

OPTIONAL INFORMATION to help locate records:

- Former names: Include any other names that have been used when receiving benefits or services.
- Client identification number: Provide any number that NWSP may have assigned.
- Other identification number: Include any other identifier that could help locate NWSP records. Provide a social security number if necessary.
- Date and location of services: Provide this information to help NWSP identify and locate the records you want disclosed.

PERSON RECEIVING RECORDS:

- Identification: Please fill out this section as fully as possible so we can contact the person or organization who will have access to your confidential information.
- Reason for Disclosure: This information is required before NWSP can share drug and alcohol or mental health records. If you do not fill in this field, NWSP will note the reason for disclosure as being at your request.

AUTHORIZATION:

- Parts of NWSP: Please mark either the parts of NWSP you want to disclose records or mark the bottom box in this section if you want to give access to any records NWSP has about you. Write in the name of program in "Other" if not in the list.
- Information disclosed: Indicate what records that you want disclosed. You may allow disclosure of all or part of your NWSP client or other confidential records. You may also limit disclosure to client records held only by the parts of the agency marked in the section above, or to specific records listed on this form or on an attachment you sign. If there are any limitations on what records you want disclosed, either list specific records or describe the limits, such as by date of services or type of record.
- Restricted records: If any of the records may include information about HIV/AIDS or STD testing or treatment, mental health treatment, or drug and alcohol services, you must check each item to allow NWSP to disclose these records. You need to complete a separate form to authorize disclosure of psychotherapy notes (45 CFR 164.508(b) (3) (ii)).
- Validity: This form is valid to give access to information currently held by NWSP. Your permission expires 180 days after signature or on any other date or event you provide. If you do not provide a date, the authorization will be valid for 180 days. You may revoke the authority to release records in writing at any time but it will be too late to take back information already produced.
- Cost: The public records act in RCW 42.56.120 and WAC 388-01-080 allow NWSP to charge for copies of records plus mailing costs. State hospitals and health care facilities may charge for patient records under Chapter 70.02 RCW.

SIGNATURES:

- If you are the subject of the records, sign and also print or type your name below. Insert the date you signed plus your telephone or contact number.
- If you are signing for another person, indicate why you can do so on the last line and attach a copy of the court order or other document giving you legal authority. Children must also sign to give permission to disclose their own confidential records if they are over the age of consent (13 for mental health and drug and alcohol services; 14 for information about HIV/AIDS or other STDs; any age for birth control and abortions; 18 for health or other records).
- Witness or notary: A witness or notary may be needed to verify your identity if you do not submit this form in person or if a program requests verification. This person should sign and print his or her name.

NOTICE TO NWSP: If these records contain HIV or STD information, NWSP must notify recipients that the information is confidential and that they may not further disclose the records without a specific authorization as required by RCW 70.02.300. If NWSP sends copies of records regarding drug or alcohol services under this authorization, NWSP must include the following statement when disclosing information as required by 42 CFR 2.32:

> This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you 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 by 42 CFR part 2. 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.