Authorization to Use or Disclose Health Care Information

530 West Fir, Suite C. Sequim, WA 98382
Phone: (360) 582-1176 Fax: (888) 316-0903**
please mail if records are more than 10 pages

I Hereby Authorize:

Facility / Doctor's Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

To Release: (Please check all that apply)

___Last two years of chart records
___Specific: Chart Notes: _____ Labs/Reports: _____
Billing Records: _____ Other: _____
Only the last two years of medical records originated through this healthcare facility will be provided.

For The Purpose Of (Please check all that apply)
___ Concurrent/Referral Care ___ Transfer of Care ___ At My Request ___ Other: _____

The Health Records Of:

Name: _____ Date of Birth: _____ SSN#: _____
Contact Phone: _____ Email address: _____
Are you authorizing the release of your own records? ___Yes ___No
If not, what is your name and relationship to the patient?
Name: _____ Relationship: _____
Release of certain medical information requires minor's consent. This applies to persons age 13 to 17 for information pertaining to substance abuse and mental health information, or persons age 14 to 17 for information pertaining to sexually transmitted diseases, HIV and AIDS. Other laws may apply.

Health Records To Be Released To:

___ Self** (please indicate mailing address below) **___ Released to PPC (see above address)**
_____OtherFacility / Doctor's Name: _____ Appointment Date and Time_____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
___ If other than self. Name of person_____ Relationship:_____
**I understand if I request my records for personal use I will be charged 39 cents/page prior to receiving my records.

My Rights:

- I understand that unless revoked, this authorization is valid for 90 days from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document.
- I understand that I do not have to sign an authorization as a condition for receiving treatment or health care benefits (treatment, payment or enrollment).
- Unless specifically excluded, this authorization includes release of specially protected information requiring my explicit authorization for release. This includes referral, diagnosis and treatment information related to: (Please check or circle all that apply to **EXCLUDE** the information from authorization): Substance Abuse Mental Health Conditions Sexually Transmitted Diseases HIV/AIDS
- I understand once Pacific Primary Care has released my health care information to the above named entity, the person or organization that receives it may re-disclose the information and that it may no longer be protected by privacy laws.
- I understand release of my records may take up to 15 working days.

I have read the above Authorization to Release Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient Signature: _____ Date: _____

POA/ Patient Guardian Signature:_____ Date:_____
Please attach a copy of legal documents if you are the legal guardian or holder of Power of Attorney or
Indicate they are on file in the patient's chart by initialing here _____.